FACTORS ASSOCIATED WITH BURNOUT IN PROVIDERS WHO WORK WITH REFUGEES IN THE UNITED STATES

by

DEBORAH LEANNE SMITH

(Under the Direction of AMANDA GIORDANO)

ABSTRACT

The ongoing global refugee crisis has led to an unprecedented number of forcibly displaced individuals, with over 700,000 new asylum claims submitted in the United States in the first half of 2024 alone (UNHCR, 2024). Refugees resettling in the U.S. are supported by a network of public and private organizations, staffed by service providers who are frequently exposed to traumatic narratives and high emotional demands (Akinsulure-Smith et al., 2018). This exposure places them at elevated risk of burnout (Kim, 2017; Roberts et al., 2021) – a psychological syndrome characterized by emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment (Maslach & Jackson, 1981). Although burnout has been widely studied among helping professions, research specifically examining refugee service providers in the United States remains limited, particularly from a systemic perspective.

Guided by Bowen Family Systems Theory (BFST), this study sought to examine burnout among refugee service providers through both individual and organizational lenses. Using a quantitative, cross-sectional predictive design, this study employed a three-step hierarchical multiple regression comprised of demographic variables (i.e. age,

gender, and history of forced migration), known predictive variables (i.e. coping mechanisms, personal history of trauma, perceived organizational support) and differentiation of self to examine the predictors of burnout. Findings showed that age, a history of forced migration, perceived organizational support, and personal history of trauma are predictors of burnout among refugee service providers. Implications for counselors, counselor educators, and future research are also included.

INDEX WORDS: Burnout, Refugees, Refugee Service Providers, Trauma, Perceived Organizational Support, Coping, Differentiation of Self, Bowen Family Systems Theory

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DEDICATION

This dissertation is lovingly dedicated to my husband, Michael, whose partnership has always been more than I deserve, and my sons Zachary and Nathan, and daughter Abby – I am endlessly proud of you every single day.

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*May God bless you with **discontent** with easy answers, half-truths, superficial relationships, so that you will live from deep within your heart.*
*May God bless you with **anger** at injustice, oppression, abuse, and exploitation of people, so that you will work for justice, equality, and peace.*
*May God bless you with **tears** to shed for those who suffer from pain, rejection, starvation and war, so that you will reach out your hand to comfort them and to change their pain to joy.*
*May God bless you with the **foolishness** to think you can make a difference in this world, so that you will do the things which others tell you cannot be done.*
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I end this with thanking God – you are always faithful. *"He will never break His promise, though the stars should break faith with the sky" (My Deliverer, Rich Mullins)*

TABLE OF CONTENTS

Page

LIST OF TABLES

Page

CHAPTER 1

INTRODUCTION

In light of the global refugee crisis, this chapter will present a discussion of the significant needs of providers who serve refugees in the United States, with a particular focus on burnout. Additionally, an overview of factors that may predict burnout will be presented, along with an overview of deficits in the literature regarding burnout in refugee service providers, underscoring the need for the proposed study. Furthermore, the chapter outlines the theoretical framework used in this study, presents the research question, provides a brief overview of the study, explains its significance, and defines key terms.

Burnout is recognized as a psychological syndrome marked by emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment, and is frequently observed among members of caregiving professions (Maslach & Jackson, 1981). Researchers have found that burnout leads to high levels of attrition and turnover in workplaces and contributes to poor client care and outcomes (Morse et al., 2012; Paris & Hoge, 2009). Working with clients whose needs require high emotional engagement increases the risk of burnout (Maslach & Leiter, 2017; Morse et al., 2012). Not surprisingly, providers working with refugees are especially at risk for the syndrome of burnout due to the high emotional demands of their work, which exposes them to individuals who have experienced extreme levels of trauma (Kim, 2017; Roberts et al., 2021).

According to the United Nations High Council for Refugees (UNHCR), as of June 2024, over 122 million people have been forcibly displaced globally due to wars, violence, human

rights violations, or persecution (UNHCR, 2024). While most individuals forced to flee are internally displaced (i.e., remaining in their country of origin), approximately 40 million are refugees, or those who have had to flee their home country and seek safety in another country due to unlivable conditions. The status of 'refugee' is a legal designation provided by international law that indicates an individual cannot return home due to documented risk to their life or wellbeing. The global refugee crisis that has displaced millions of individuals is expected to escalate further due to war and unrest across the world, particularly in Sudan and Ukraine. In fact, 5.3 million people were forcibly displaced in the first six months of 2024 alone. During this same period, the United States received over 700,000 new asylum claims, or formal requests for international protection made by individuals fearing persecution in their home country (UNHCR, 2024).

Refugees who resettle in the United States are supported by hundreds of public and private organizations that assist them with all facets of the resettlement process, including finding housing, applying for financial and medical benefits, seeking medical and mental health care, securing employment, receiving language support, and integrating into their new communities (U.S. Department of State, 2023). This support is provided by a substantial number of both employed and voluntary individuals across the United States (Migration Policy Institute, 2024). While addressing the needs of this community, refugee service providers are frequently exposed to stories and experiences of profound loss and severe trauma (Akinsulure-Smith et al., 2018). Indeed, exposure to trauma is a defining feature of the refugee experience, frequently occurring prior to displacement, throughout the migration process, and even after resettlement in a new country (Jani et al., 2020; Nickerson et al., 2011). Research indicates that providers

serving refugee populations face a heightened risk of burnout due to the significant exposure to trauma inherent in their work (Sifaki-Pistolla et al., 2017).

While the body of research on burnout among refugee service providers is growing, it remains limited and predominantly focused on providers in other countries (Birger et al., 2020; Posselt et al., 2019). This gap is notable given that the United States resettles more refugees annually than any other country (UNHCR, 2024). In addition, the complex interplay between the human suffering to which providers are exposed, the demands of their roles, organizational challenges within their workplaces, and providers' own personal experiences make it challenging to determine effective clinical strategies to support this population (Eriksson et al., 2009). Therefore, it is imperative for researchers to continue examining the syndrome of burnout among refugee service providers in order to identify unique variables that predict burnout among this population.

Conceptual Framework for the Study

Bowen Family Systems Theory (BFST) will serve as the theoretical framework for this study, providing a foundation for the study's hypothesis and guiding the selection of independent variables. BFST is a framework for understanding human behavior that conceptualizes family, workplace, or societal systems as interconnected emotional units where the experiences and emotions of one member influence the entire system (Kerr & Bowen, 1988). Simply put, if one member of a system is struggling emotionally, it affects the entire system (Gilbert, 2004). Differentiation of self is a key feature of BFST, referring to an individual's ability to remain objective and calm even when others in the system are anxious (Kerr & Bowen, 1988). Thus, BFST suggests that an individual's symptoms may be reactions to dynamics in a workplace system, such as differentiation of self, rather than being solely attributable to individual factors,

such as one's coping mechanisms (Beebe & Frisch, 2009; Kerr & Bowen, 1988). For example, an individual exhibiting symptoms of burnout may have poor emotional regulation skills (an individual factor); however, if the workplace is highly reactive or conflictual, the impact of the differentiation level of the system must also be considered. Therefore, BFST is an appropriate framework from which to consider the phenomenon of burnout due to its focus on both individual and systemic issues contributing to an individual's functioning. Examining burnout through the lens of BFST and particularly the concept of differentiation of self, offers a unique perspective on the underlying causes of burnout among refugee service providers, which may inform the development of innovative interventions to mitigate its effects. By addressing the complex phenomenon of burnout in this population through a distinctive theoretical framework, counselors can more effectively respond to the needs of service providers, improving their wellbeing, and ultimately enhancing their capacity to best support their refugee clients.

Differentiation of self has been identified as a predictor of burnout in other populations (Beebe & Frisch, 2009); however, this relationship has not been examined among refugee service providers. Investigating the influence of differentiation of self on burnout in this population is warranted in light of the unique experiences of providers and their workplace systems. Additionally, it is crucial to explore other established predictors of burnout among refugee service providers through the lens of BFST. These predictors include personal history of trauma (Akinsulure-Smith et al., 2018), negative coping mechanisms (Espinosa et al., 2019), and poor organizational support (Eriksson et al., 2009).

While these previously identified variables have been studied individually, they have not been explored simultaneously in association to burnout within this population. Moreover, their examination through a systemic framework, such as BFST, remains absent from the literature. A

simultaneous examination of these variables among refugee service providers through a BFST lens may illuminate the dynamic interplay of factors contributing to burnout and provide insight into the unique variance explained by each factor. Consequently, it is appropriate to consider differentiation of self, coping mechanisms, a personal history of trauma, and perception of organizational support among refugee service providers to better understand predictors of burnout.

Statement of the Problem

Burnout has been a subject of research for decades due to its profound impact on individuals who experience it and its secondary effects on the clients they serve (Maslach, 2003; O'Conner et al., 2018). With the global refugee crisis escalating at an unprecedented rate, the increased risk of burnout among refugee service providers has become a growing focus in the literature (Akinsulure-Smith et al., 2018; Kavukcu et al., 2019; Kim, 2017; Roberts et al., 2021). As the numbers of refugees fleeing conflict is expected to rise exponentially due to ongoing global unrest (UNHCR, 2024), it is critical to address the issue of burnout in providers attempting to meet their needs.

Previous research has shown that providers are often working with limited resources in the context of overwhelming need (Eriksson et al., 2009; Espinosa et al., 2019), while also being exposed indirectly to extreme trauma (Sifaki-Pistolla et al., 2017), a factor that has been strongly linked to burnout (Cieslak et al., 2014). Burnout is a significant risk for this population as a result, leading to psychological symptoms for the providers and poor client care for the refugees they serve (Ager et al., 2012; Chatzea et al., 2018; Roberts et al., 2021). Understanding the predictors of burnout within this population is essential to developing targeted interventions that mitigate its effects, promote provider wellbeing, and ensure effective care for refugee clients.

Existing research on burnout among refugee service providers has primarily focused on the experiences of providers in other countries (Chatzea et al., 2018; Denkinger et al., 2018; Kim, 2017; Sagaltici et al., 2022). Furthermore, much of this research emphasizes individual factors contributing to burnout, leading to individual solutions such as increasing healthy coping mechanisms (Akinsulure-Smith et al., 2018, Kim, 2017). Building on this foundation, the proposed study seeks to address a critical gap in the literature by examining burnout among providers who work directly with refugees in the United States. Specifically, it investigates the predictive role of four variables (differentiation of self, coping mechanisms, personal history of trauma, and perception of organizational support) simultaneously within the same model. In addition, utilizing a BFST framework, this study goes beyond an individual focus to incorporate systemic considerations, exploring both the characteristics of individual providers and organizational dynamics that may contribute to worker burnout. With this information, this study aims to assist counselors, counselor educators, policymakers, and directors of refugee service organizations in more effectively supporting refugee service providers as they serve the needs of the growing population of displaced individuals in the United States.

Purpose of the Study

Existing literature has demonstrated a connection between burnout in refugee service providers and poor coping mechanisms (Espinosa et al., 2019), personal history of trauma (Akinsulure-Smith et al., 2018), and poor organizational support (Eriksson et al., 2009). In addition, low differentiation of self has been connected with burnout in research regarding nurses (Beebe & Frisch, 2009) and counselors (Kursuncu et al., 2023). However, no research to date has examined the connection between burnout and differentiation of self in refugee service providers. Furthermore, these four variables have not been considered simultaneously as

predictors of burnout among providers in the U.S. Therefore, this study seeks to examine differentiation of self, coping mechanisms, personal history of trauma, and perception of organizational support as predictors of burnout among refugee service providers, after controlling for demographic variables, with the aim of illuminating both the unique and shared variance of these variables.

Research Question

This study is designed to examine the extent to which demographic factors (i.e., gender, race/ethnicity, age, history of forced migration, and time on the job), a unique combination of variables known to be associated with burnout among refugee service providers (i.e., coping mechanisms, personal history of trauma, and perception of organizational support), as well as the distinctive variable of interest, differentiation of self, predict burnout among providers who work directly with refugees in the U.S. Specifically, the following research question will frame this study: Does differentiation of self explain a unique amount of variance of burnout among providers who work directly with refugees in the United States above and beyond known predictive factors (i.e., coping mechanisms, personal trauma history, and perception of organizational support) after controlling for demographic variables (i.e. gender, race/ethnicity, age, history of forced migration, and time on the job)?

Brief Overview of the Study

To investigate how the study variables uniquely predict burnout among refugee service providers, this study will use a quantitative, cross-sectional, predictive research design. I will obtain approval from the university's institutional review board to conduct this study. Data collection will occur via an online survey distributed to refugee service providers employed or volunteering at Refugee Resettlement Agencies (RRAs) in the United States as well as affiliated

organizations, with a desired total sample size of 125. This study will utilize a combination of convenience and snowball sampling through the use of contact lists specific to staff employed or volunteering at these agencies, obtained through professional networks, as well as via publicly available contact information for staff associated with RRAs and affiliated organizations. Email will be used for recruitment, and participants will be encouraged to share the email with others who may qualify and be willing to participate in the study.

I will use a demographics questionnaire to assess participants' gender, race/ethnicity, age, history of forced migration, time on the job, education level, specific role or position in the agency, frequency of interaction with refugees, and religious/spiritual affiliation. Differentiation of self will be measured via the Brief Differentiation of Self Inventory (Brief DSI; Sloan & van Dierendonck, 2016). Coping mechanisms will be assessed using BriefCOPE (Carver et al., 1989), and personal history of trauma will be measured using the Life Events Checklist (LEC-5; Weathers et al., 2013). The Perceived Organizational Support Scale (POS-8; Eisenberger et al., 1997) will be utilized to assess the perception of organizational support. Burnout will be measured via the Copenhagen Burnout Inventory (CBI; Kristensen et al., 2005).

To answer the research question, I will employ a multiple hierarchical regression analysis. The regression model will include three sets of predictor variables added in three separate steps: step one will include demographic variables (i.e. gender, race/ethnicity, age, history of forced migration, and time on the job), step two will include previously identified predictors variables (i.e. coping mechanisms, personal history of trauma, and perception of organizational support), and step three will include differentiation of self. The criterion variable for the regression model will be burnout scores. Therefore, the study seeks to determine whether differentiation of self explains the variance of burnout among refugee service providers over and

above coping mechanisms, personal trauma history, and perception of organizational support, after controlling for gender, race/ethnicity, age, history of forced migration, and time on the job.

Significance of the Study

Research regarding burnout is plentiful, however, minimal research exists exploring this phenomenon among refugee service providers. Furthermore, current research often explores the experiences of refugee service providers in other countries, exposing a significant gap in the literature. Additionally, differentiation of self, while connected to burnout among other populations (Beebe & Frisch, 2009; Kursuncu et al., 2023), has not been studied regarding burnout among refugee service providers specifically. Therefore, this study is designed to address these gaps, seeking to provide information that can better inform clinical interventions for refugee service providers experiencing burnout. Moreover, this study adopts the distinct framework of BFST, suggesting an exploration of individual and systemic factors that may contribute to burnout in this population. A BFST informed perspective offers a novel approach that may yield important new insights for counselors and counselor educators as they meet the needs of this critical workforce. Finally, a growing body of research is examining the experiences of refugees as they continue to flee wars and unrest in unprecedented numbers (UNHCR, 2024). However, research examining the experiences of providers serving refugee populations is more limited, even as the population of refugees grows exponentially. This study aims to address these issues, with the goal of adding to the knowledge base regarding the phenomenon of burnout among providers. The results have the potential to help counselors and counselor educators better mitigate the effects of burnout, and potentially inform policies that impact these providers, enhancing their ability to care well for the refugee populations they serve.

Definition of Terms

Burnout: A psychological syndrome evidenced by ongoing feelings of exhaustion, cynicism, and a decreased sense of personal effectiveness. Burnout can result from chronic stress in one's personal or professional life.

Coping mechanism: A behavior, thought, or emotion that people use to manage stress, anxiety, or negative emotions. Coping mechanisms can be healthy or unhealthy.

Differentiation of Self: A state of psychological maturity in which an individual is able to separate personal thoughts, feelings, and reactions from those of others, remaining emotionally regulated and objective even when others are reactive or anxious.

Organizational support: The degree to which an organization demonstrates care and concern for the well-being of employees or volunteers, valuing their contributions and offering support to assist them in being successful.

Refugee: An individual who has fled their home country, seeking safety in another country, to escape war, violence, persecution, or human rights violations.

Refugee Service Providers: Individuals who provide social services to refugees such as employment assistance, cultural orientation, case management, medical or mental health care, legal services, or housing assistance. These providers can be paid employees or work on a volunteer basis.

Trauma: An emotional response to a distressing event or series of events that is experienced as harmful emotionally or physically, that has lasting impact on an individual's functioning.

Chapter Summary

Refugee service providers face distinct challenges due to the demanding nature of their work. As the number of people fleeing wars, violence, and persecution grows daily, the intensity

of refugee service work has also increased. While research on the experiences of providers serving refugees is expanding, it remains limited, with much of the existing research addressing the experiences of providers in other countries. Studies have highlighted a high prevalence of burnout among refugee service providers (Ager et al., 2012, Sifaki-Pistolla et al., 2017), indicating that the phenomenon is a critical issue among providers. Furthermore, research has established that burnout is predicted by coping mechanisms (Espinosa et al., 2019), personal history of trauma (Akinsulure-Smith et al., 2018), and perception of organizational support (Eriksson et al., 2009). However, the impact of these variables simultaneously has not been examined. Additionally, differentiation of self, which has been established as a predictor of burnout in other populations (Beebe & Frisch, 2009; Kursuncu et al., 2023), has not been examined with regard to burnout among refugee service providers. Without a comprehensive, systemic view of the potential predictors of burnout in this population, counselors and counselor educators risk overlooking critical information, leading to ineffective interventions or a failure to address the issue altogether. Thus, this study plans to explore these predictors simultaneously, through a BFST framework, to determine the extent to which they explain the variance of burnout in refugee service providers.

CHAPTER 2

REVIEW OF LITERATURE

The purpose of this chapter is to present a review of relevant literature related to burnout factors among social service providers working directly with refugees in the United States. In this chapter I will provide an overview of the prevalence of forced displacement globally, followed by a description of the resettlement process for refugees who migrate to the United States. I will describe the experiences of trauma in refugee populations, as well as the impact of vicarious trauma and secondary traumatic stress on providers who work with refugees, including experiences of burnout. I will then propose a study that aims to understand the factors that predict burnout among providers working with refugees. The results of this study can help better equip counselors to work with refugee service providers, as well as the refugees they serve.

Refugee Experiences in the United States

The current global crisis of displaced people is unprecedented in its scope (Thompson & Dunmore, 2023; United Nations High Commissioner for Refugees [UNHCR], 2023). UNHCR reported that at the end of 2023, there were 117 million displaced people globally, 36.4 million of whom were refugees (Thompson & Dunmore, 2023; UNHCR, 2024). International law defines who is a refugee, and the current definition, which was developed in 1951 at the Global Refugee Convention, states that a refugee is a person who,

> owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside

> the country of their nationality and is unable or, owing to such fear, is unwilling to avail themselves of the protection of that country (UNHCR, 2024, para. 4).

The UNHCR has a mandate to support refugees globally and identified three solutions in order to assist refugees to rebuild their lives in a stable community. These three solutions, called durable solutions, include (a) repatriation back into their home country if it is safe to do so, (b) integration into the country where they initially sought asylum, or (c) resettlement to a third country (UNHCR, 2024). The vast majority of individuals who are forcibly displaced will remain and assimilate into the country where they sought asylum or will return home (UNHCR, 2024), while fewer than 1% will be considered for resettlement (Hebrank, 2014; HIAS, 2023; UNHCR, 2024). In fact, only 24 countries received refugees for resettlement in 2023, with the United States receiving over 75,000, which was the largest number among all receiving nations (UNHCR, 2024). The number and location of refugees dramatically changes each year as new conflicts erupt all over the world. For example, at the end of 2023, three out of four refugees originated from five countries experiencing high rates of conflict and violence: Afghanistan, Syria, Venezuela, Ukraine, and South Sudan (UNHCR, 2024).

History of Refugees in the U.S.

The history of the legal framework for protecting refugees began with the appointment of the first High Commissioner for Refugees in 1921 by the League of Nations (later the United Nations) (History of UNHCR, 2024; International Counseling & Community Services, 2015). Later, in 1951, the Office of the United Nations High Commissioner for Refugees (also known as the UN Refugee Agency) was established and given the mandate to protect refugees who remained displaced after World War II ended (Hebrank, 2014; History of UNHCR, 2024). During this time, the United States responded to refugee needs in improvised, unstructured ways

and began to develop a partnership between the government and private agencies to meet these needs more consistently (Brown & Scribner, 2014). Spurred on by an influx of refugees after the Vietnam War, the U.S. Congress passed the Refugee Act of 1980, adopting the current definition of a refugee and standardizing the resettlement process in the United States (Brown & Scribner, 2014; International Counseling & Community Services, 2015; USCIS, 2023). The Refugee Act also solidified the unique public-private partnership that assists refugees in the resettlement process in the United States to this day (Brown & Scribner, 2014). Since this act was passed, the United States has resettled over 3.2 million refugees (Migration Policy Institute, 2024; U.S. Department of State, 2024). In 2023, Texas received the highest number of refugees among all U.S. states, followed by New York and California (Migration Policy Institute, 2024). Although the U.S. has resettled a large number of refugees, the process of refugee resettlement is quite extensive and multilayered.

Refugee Resettlement Process

Each year the President of the United States establishes a ceiling for refugee admissions for the upcoming year (Migration Policy Institute, 2024). Over the past five years, this ceiling has fluctuated from 18,000 in 2020 to its current 125,000 in 2024 (Migration Policy Institute, 2024). Despite the set ceiling, it is common for the actual number of refugees admitted into the United States to be lower. For example, in 2023, the admission number set by the President was 125,000; however, only 75,000 individuals were admitted (Migration Policy Institute, 2024). This discrepancy is due to many factors, including administrative challenges, the need for thorough security screenings, policy changes, and conditions in the countries from which refugees are fleeing (Migration Policy Institute, 2024).

While some refugees are referred to the U.S. federal government for resettlement by a United States Embassy or humanitarian aid organizations, most are referred by UNHCR (Hebrank, 2014; UNHCR, 2024). Prior to referring refugees to the United States, UNHCR utilizes a careful and detailed assessment process to ensure that they meet the criteria for resettlement (Triggs, 2024). Importantly, refugees are not given the right to decide which country to be referred to for resettlement (Triggs, 2024). Instead, UNHCR considers several factors when choosing a country to refer refugees, including the country's quotas, the ability of that country to meet a refugee's specific needs, whether the refugee has family in the country, and the urgency of the resettlement need (Triggs, 2024). Thus, UNHCR has developed structures and assessment tools to ensure fair, transparent, and predictable processes for all refugees, allowing them to identify the most vulnerable individuals who are most in need of resettlement assistance (Triggs, 2024).

Once a refugee is referred for resettlement in the United States, the U.S. government screens them to determine if they will be selected (UNHCR 2024). These screenings are conducted by the Department of State's Bureau of Population, Refugees and Migration (PRM), which has offices throughout the world (Hebrank, 2014). The screenings include background checks, health screenings, and in-person interviews (Hebrank, 2014; UNHCR, 2023). Once selected, refugees travel to the United States utilizing a loan from the International Organization for Migration, which is expected to be repaid within three to five years (Hebrank, 2014; World Relief, 2024). The selected refugees are then assigned to receive sponsorship from one of ten non-profit refugee resettlement agencies (RRAs) contracted with the Department of State to resettle in the United States (Rush, 2024). RRAs partner with local affiliates to place refugees where they are determined to have the highest chance of success based on housing availability

and employment opportunities (U.S. Department of State, 2023). There are approximately 350 affiliates, which are located throughout the United States (U.S. Department of State, 2024). Through the partnerships between RRAs and affiliates, refugees are supported in finding housing, enrolling children in school, applying for available benefits, seeking medical care, securing employment, receiving care for mental health concerns, and integrating into their new communities (U.S. Department of State, 2023).

Services Provided to Refugees in the United States

Once they arrive in the U.S., refugees selected to resettle are supported by a wide array of providers, including personnel from government agencies, non-profit organizations, community-based groups, educational institutions, and faith-based organizations (Office of Refugee Resettlement [ORR], 2024; Triggs, 2024; U.S. Department of State, 2023). Services provided to refugees include job training and placement, language instruction and support, translation, childcare, citizenship support, cultural orientation, medical and dental services, mental health services, and housing support (ORR, 2024; Triggs, 2024). Additionally, local community groups and volunteer organizations provide other forms of networking and social support as well (ORR, 2024).

A substantial number of providers are associated with RRAs. For example, the International Rescue Committee (IRC) is one of the ten RRAs that assists with resettling refugees, with locations in 28 U.S. cities. In Atlanta alone, the IRC employs over 100 individuals, with almost 3000 employed across the United States (IRC, 2024). Taking into account the other nine RRAs, the numbers of employed providers for refugees likely is near 50,000. This number, however, does not include unpaid volunteers, who vastly outnumber employees at most agencies (Migration Policy Institute, 2024). In sum, the number of providers

required to meet the needs of the refugee population in the United States is substantial and growing annually.

Experiences of Trauma Among Refugees

Considering the very definition of "refugee", it is not surprising that many (if not all) of these individuals experience trauma. Thus, understanding the definition of trauma and trauma-related disorders is essential for accurately conceptualizing the experience of refugees and, in turn, the providers who work with them.

Definition and Characteristics of Trauma

Defining trauma can be difficult as the word is often used to refer both to horrific events, as well as the set of symptoms that can result from exposure to a horrific event. The understanding of trauma in the counseling field has its roots in Sigmund Freud's explorations of puzzling symptoms witnessed in victims of accidents or war (Herman, 1997; Pau et al., 2020). This exploration began to develop the foundation for an understanding about how traumatic events affect individuals both psychologically and emotionally. The concept and definition of trauma continued to develop as researchers noticed the impacts of major global events such as the Vietnam War (Pau et al., 2020). This deeper understanding culminated in the inclusion of posttraumatic stress disorder (PTSD) in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) (American Psychiatric Association [APA], 1980; Herman, 1997; Pau et al., 2020). Since 1980, the mental health profession's understanding of trauma and its effects has continued to grow, resulting in a broadening of what constitutes a traumatic event from war and catastrophes to sexual violence and ongoing abuse, or other events that impact an individual's functioning (Pau et al., 2020).

With added knowledge and nuance, the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) defined trauma as "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being" (p. 7). Specifically, events that are traumatic overpower or devastate an individual's central nervous system's natural coping abilities and impact the individual's ability to think and perceive their world (van der Kolk, 2014). Trauma also compromises the brain's alarm system and ability to accurately decide what might be irrelevant information that can be dismissed, versus information that reflects danger and should be considered (van der Kolk, 2014). Moreover, trauma negatively impacts an individual's connections in intimate relationships and often results in the traumatized person superimposing their trauma onto every area of their life (Herman, 1997; van der Kolk, 2014).

Individuals can develop symptoms after experiencing a one-time traumatic event such as a natural disaster, or after long-term chronic patterns such as racism, discrimination, or abuse (SAMHSA, 2023). In addition, trauma can be experienced at the individual (e.g., intimate partner violence), family (e.g., addiction issues), community (e.g., natural disaster, religious persecution) or global level (e.g., pandemic, war) (SAMHSA, 2023). When trauma is experienced at more than one level, it has a compounding impact, often resulting in more significant symptoms (SAMHSA, 2023). Furthermore, historical trauma and structural racism experienced by specific groups exacerbates the impact of trauma over time (SAMHSA, 2023). In summary, the effects of trauma are pervasive and significant, manifesting in a variety of symptoms and, potentially, trauma-related disorders.

Trauma-Related Disorders

The experience of trauma can lead to a range of symptoms and mental health concerns. Indeed, trauma exposure is one of the most salient predictors and risk factors for poor mental health, resulting in diagnoses and symptoms of depression, anxiety, emotion dysregulation, aggression, and posttraumatic stress disorder (PTSD) (Al Jowf et al., 2022; APA, 2022; Herman, 1997; Moore & Newbauer, 2014). The variability of symptoms related to trauma exposure resulted in the inclusion of a new category called "Trauma and Stressor Related Disorders" in the *Diagnostic and Statistical Manual of Mental Disorders* fifth edition (DSM-5, APA, 2013), and expanded upon in the most recent edition, the DSM-5TR (APA, 2022). This chapter delineates seven primary diagnoses with a shared key diagnostic feature: exposure to a traumatic or stressful event. The diagnoses include Reactive Attachment Disorder (RAD), Disinhibited Social Engagement Disorder (DSED), Posttraumatic Stress Disorder (PTSD), Acute Stress Disorder (ASD), Adjustment Disorders, Prolonged Grief Disorder, and Other Specified Trauma and Stressor-related Disorders (APA, 2022). While all of these diagnoses have significant effects, PTSD is the most common and the most debilitating condition following trauma exposure (Al Jowf et al., 2022; APA, 2022). It is important to note, however, that even subclinical effects of trauma are significant, yet they are more difficult to measure, thus requiring counselors to be aware of and address all levels of impact (Hoffman et al., 2014).

RAD and DSED are conditions identified in children who experience profound early childhood attachment disruptions (APA, 2022). While their symptom profiles differ considerably, both arise from a lack of adequate caregiving during infancy and early childhood and are often diagnosed in children under the age of five (APA, 2022). Prolonged Grief Disorder is diagnosed when an individual experiences prolonged, debilitating distress following the death

of a loved one (APA, 2022). Unspecified Trauma and Stressor-Related Disorders encompass symptoms arising after a traumatic event, which significantly impair an individual's functioning, but do not fully meet the diagnostic criteria for other trauma and stressor-related disorders (APA, 2022).

Adjustment disorders are characterized by distress after a stressful life event and can be diagnosed after exposure to a stressor of any severity, typically resolving in six months or less (APA, 2022). Among the trauma-related disorders, adjustment disorders are commonly diagnosed and can co-occur with other mental health issues such as PTSD or depression (APA, 2022; Bajbouj et al., 2021). Acute stress disorder presents with symptoms that match PTSD, however, are time limited (APA, 2022). If an individual exhibits symptoms beyond one month, a diagnosis of PTSD becomes more appropriate (APA, 2022).

Arguably the most well-known trauma-related disorder is PTSD, which affects 8.3% of the general population (Kilpatrick et al., 2013). PTSD is characterized by symptoms in four categories: intrusion, avoidance, hyperarousal/reactivity, and negative changes in cognition and mood (APA, 2022; Herman, 1997). Intrusion describes the reliving of a traumatizing event through nightmares, flashbacks, or memories that interfere with normal functioning (APA, 2022; Herman, 1997). Avoidance refers to a state of shut down, disassociation, or numbing experienced by people who are in powerless positions (APA, 2022; Herman, 1997). Hyperarousal is a chronic state of activation in the sympathetic nervous system, causing a person to be on constant alert for danger (APA, 2022; Herman, 1997). Negative changes in cognition and mood is evidenced in beliefs about the self or the world as a result of trauma, such as "I can never be safe", or "the abuse was my fault" (APA, 2022). Traumatized individuals often swing between intrusive and constrictive responses; this oscillation is a distinctive feature of PTSD

(Herman, 1997; van der Kolk, 2014). These symptoms and oscillating states can be so distressing to people who have experienced trauma that healthy relationships and life rhythms are often impossible (van der Kolk, 2014). Thus, the impact of trauma exposure is substantial, warranting an exploration of its effects on vulnerable populations such as refugees and those who serve them.

Prevalence of Trauma in Refugee Populations

It is unsurprising that refugees are at higher risk for trauma exposure and PTSD than the general population (Giacco et al., 2017; Henkelmann et al., 2020). In order to receive the legal status of refugee, a person must have experienced significant trauma in their home country, such as community violence, acts of war, assault, persecution, or even torture (Hickerson & Dunsmore, 2016; Jensen, 2023). Moreover, after resettlement in another country, refugees often experience post-migration trauma as well, including separation from family, poverty, acculturation stress, and racism (Hijazi et al., 2014; Olivarrieta & Benuto, 2022). Indeed, Knipscheer et al. (2015) researched trauma exposure in refugee populations and found refugees reported exposure to an average of 11.2 traumatic events over their lifetime, with almost 80% reporting being close to death, 74% being forced to separate from family, and 72% reporting the murder of a family member or friend. The authors also found that 84% of participants, when asked to evaluate the past week, reported PTSD symptoms that rose to clinical levels (Knipscheer et al., 2015). Other researchers have found high levels of PTSD among refugee populations, ranging from 37% to 49% (Hamrah et al., 2020; Henkelmann et al., 2020). Further complicating the impact of trauma in refugee populations is the cumulative experience of trauma in pre-migration, migration, and post-migration stages of the displacement process (Jani et al., 2020; Nickerson et al., 2011).

Pre-Migration Trauma

Researchers interested in the experiences of refugees typically divide the migration process into three stages and examine the psychological impacts of each stage: (a) pre-migration, (b) migration, and (c) post-migration (International Counseling and Community Services, 2015; Jani et al., 2020; Shi et al., 2021). The pre-migration process encompasses the time period in which events occur that result in an individual leaving their home country (International Counseling and Community Services, 2015; Shi et al., 2021). This time period varies greatly in length, sometimes encompassing days, sometimes extending over generations (International Counseling and Community Services, 2015). The pre-migration period is often defined by violence in the community, instability in housing and basic human needs, witnessing violence toward or murder of a family member, destruction of property, and targeted persecution and torture (Andisha & Lueger-Schuster, 2023; Bogic et al., 2015; International Counseling and Community Services, 2015; Jani et al., 2020). It is important to note that the decision to leave one's home country is extremely difficult and complex. Individuals commonly wait as long as possible before leaving, typically fleeing when fear for their own or their children's lives is the most pressing concern (International Counseling and Community Services, 2015).

Pre-migration trauma can be severe and is associated with higher risk of anxiety and mood disorders, PTSD, and trauma-related disorders (Andisha & Lueger-Schuster, 2023; Jani et al., 2020). In a 2019 systematic review by Araujo et al., the scholars found that sexual violence was documented in nearly all of the 60 articles reviewed, with prevalence rates reaching as high as 99% among refugee populations. Pre-migration trauma in any form is extremely common, with research reporting prevalence of up to 89% (Kim et al., 2019; Steel et al., 2009; Steel et al.,

2017). Unfortunately, the effects of the initial traumatic event may be compounded by trauma that occurs during the migration process.

Migration Trauma

The migration process refers to the time period between the point when a refugee leaves home and when they reach a place of relative safety (International Counseling and Community Services, 2015). Like pre-migration, the migration process is variable: it can be short, or very long, sometimes requiring a refugee to live in hiding for long periods of time or walk hundreds of miles (International Counseling and Community Services, 2015; Jani et al., 2020). Refugees flee in many differing ways, often walking, riding horses, boarding a boat, or hiding in a vehicle while being smuggled to safety (International Counseling and Community Services, 2015; Jani et al., 2020). The migration process itself is highly unstable and unsafe, with refugees often hiding from authorities or soldiers, facing hunger and dehydration, or even dangerous animals (International Counseling and Community Services, 2015; Jani et al., 2020). In addition, refugees at times start the migration process with injuries sustained prior to flight, with no time to seek medical care (Andisha & Lueger-Schuster, 2023).

Included in the migration phase is any time a refugee spends in a refugee camp or displaced in a location other than their home. While the amount of time a refugee spends in a camp can vary widely based on the circumstances in their location, the average timespan is 17 years (International Counseling and Community Services, 2015). Time spent in refugee camps is highly correlated with negative impacts on mental health, with the risk of mental health disorders and PTSD increasing the longer individuals stay in camps (Pau et al., 2020; UNHCR, 2023). The majority of refugees throughout the world do not live in camps, however, but instead live in cities that are not their final destination (UNHCR, 2023). Those who live in cities may have

access to employment and experience more autonomy, but they are still dependent on available opportunities in their specific location while waiting for decisions about their resettlement (UNHCR, 2023). Refugees in camps or displacement cities are often living in poverty and struggle to meet basic needs such as accessing clean water or food (UNHCR, 2023).

Regardless of destination, whether it be a camp or a refuge city, refugees are highly likely to encounter threats of physical violence during the migration process (Mohammadsadeghi et al., 2022; Saadi et al., 2023). While the frequency of physical trauma during migration is variable, living under the perceived threat of violence is universal for refugees (Orsini et al., 2022). For example, Arsenijevic et al. (2017) discovered that almost 30% of participants in their study reported physical violence during their flight to safety, with state authorities perpetrating these acts of violence 65% of the time. In addition, in a 2020 study of 240 displaced individuals, 94% reported incidents of physical violence, the vast majority of which were caused by beatings during the migration process (Deps et al., 2021). These studies highlight that physical violence is often a part of the migration process for refugees, further exacerbating the mental health challenges of an already-traumatized population.

Post-Migration Trauma

The post-migration period is also referred to as resettlement. The resettlement process occurs once a refugee has reached the new country that will become their home. It is important to note that most refugees do not get the chance to resettle to a new country; rather, most either return to their country of origin or make a life in exile in a camp or nearby country (International Counseling and Community Services, 2015; UNHCR, 2023). As a result, misconceptions about the post-migration period are numerous, with the most common being that a refugee's life is

easy, and their trauma is over once they reach their resettlement country (International Counseling and Community Services, 2015).

While it is true that refugees often are physically much safer after resettlement, research has shown that the post-migration period is very difficult and often filled with its own traumatic stressors (International Counseling and Community Services, 2015; Shi et al., 2021). Common post-migration stressors include economic insecurity, racial discrimination, poor language proficiency in their host country, limited employment opportunities, lack of access to affordable housing, inability to access health care services, lack of social support, and ongoing separation from family members (Andisha & Lueger-Schuster, 2024; Malm et al., 2020; Shi et al., 2021). Miller et al. (2017) suggested that daily stressors experienced by resettled refugees are the major cause of mental health issues, and should be incorporated into any treatment options, highlighting the fact that daily stressors can be just as distressing to refugees as exposure to trauma. These daily stressors are very present for refugee populations, in contrast to war experiences in their past, and thus can lead to substantial distress (Brunnet et al., 2020; Miller & Rasmussen, 2016).

Research has shown that daily post-migration stressors and traumas are at least as impactful (if not more) than pre-migration exposure to war and persecution (Miller & Rasmussen, 2010; Miller & Rasmussen, 2017). In fact, a 2017 study found that 64% of refugee participants reported significant emotional distress related to ongoing separation from family members still in their country of origin (Tinghog et al., 2017). This same study also found that feeling disrespected due to one's national background was a common post-migration experience among refugees and was strongly predictive of mental health challenges (Tinghog et al., 2017). Thus, it is evident that post-migration trauma is potentially the most immediately impactful

experience for refugees after resettlement, compounding the psychological and emotional scars of the forced migration process. Given that refugees typically endure trauma throughout all stages of the migration process, trauma becomes a defining aspect of their experience; shaping their lives, their self-perception, and how others view them. It is crucial for service providers to offer comprehensive care, which includes addressing the effects of trauma experienced by refugees. Providers who work with refugees, then, are at risk of vicarious trauma or secondary traumatic stress.

Experiences of Social Service Providers for Refugee Populations

Thousands of social service providers assist refugees throughout the resettlement process in the United States. From the moment an individual is recommended to the United States for resettlement until they are thoroughly integrated into American society, a network of public and private agencies provide comprehensive support. This collaborative effort seeks to ensure that refugees receive assistance at every phase of their transition, facilitating a smoother adaptation to their new home. Providers assist refugees with financial and documentation needs, provide legal or medical care, serve as case managers, arrange for educational and language services, facilitate the process of securing housing, and provide social support as refugees navigate the acculturation process (Brown & Scribner, 2014; Hebrank, 2014; Triggs, 2024). As such, providers for refugee populations may be attorneys, medical providers, social workers or counselors, teachers, administrators, case managers, or career specialists. Importantly, volunteers also provide these services as unpaid support to refugees, and often far outnumber the paid providers involved in the same work. Given the significant number of individuals who serve as providers, it is crucial to understand their unique experiences and potential mental health needs. Enhancing the well-

being of service providers is critical to ensure effective support for refugees amid the ongoing global refugee crisis.

Impact of Refugee Trauma on Providers

Due to their exposure to individuals who have experienced extreme levels of trauma, research suggests that professionals or volunteers who work with refugee populations are at risk for many negative psychological effects, including vicarious traumatization (VT), secondary traumatic stress (STS), and burnout (Akinsulure-Smith et al., 2018; Cieslak et al., 2014; Espinosa et al., 2019; Roberts et al., 2021; Zivanovic & Markovic, 2020). Vicarious traumatization (VT) and secondary traumatic stress (STS) both describe the emotional and psychological responses that professionals experience as a result of exposure to client trauma-related disclosures (Baird & Kracen, 2006; Ivicic & Motta, 2016). Although VT and STS are distinct constructs, they are often used interchangeably in research (Baird & Kracen, 2006; Ivicic & Motta, 2016). STS is most often used to describe a syndrome or disorder experienced by professionals whose work indirectly exposes them to trauma (Baird & Kracen, 2006; Bride & Kintzel, 2011). STS mirrors the symptoms of PTSD and can occur after brief interactions with traumatic client experiences (Baird & Kracen, 2006). VT, on the other hand, refers to changes in cognitive schema in professionals following prolonged exposure to client trauma content (Baird & Kracen, 2006; Leung et al., 2022). These changes involve negative shifts in providers' perceptions of safety, trust, and control, which in turn disrupt their fundamental views of the world and their sense of self (Baird & Kracen, 2006; Leung et al., 2023).

Research reveals a strong correlation between STS, VT, and burnout among providers who work with refugees (Akinsulure-Smith & Keatley, 2014; Akinsulure-Smith et al., 2018; Tessitore et al., 2023). Burnout is defined as a psychological syndrome characterized by

emotional exhaustion, cynicism, and a reduced sense of personal accomplishment that commonly occurs among individuals in helping professions (Maslach & Jackson, 1981). The experience of burnout is of particular concern as it leads to attrition among human service providers, which can contribute to poor quality of care for clients (Akinsulure-Smith et al., 2018; Bride & Kintzle, 2011; Tessitore et al., 2023). In a meta-analysis of 41 studies examining the experiences of different professionals who work with traumatized populations, (e.g., social workers, rescue workers, health care workers, counselors, law enforcement workers), the authors found a strong association between burnout and STS, with the association being notably stronger among female participants (Cieslak et al., 2013). These findings are corroborated by other research studies, which also reveal the high levels of STS and burnout experienced by providers working with refugees (Ager et al., 2012; Kim, 2017; Roberts et al., 2021). For example, Kim (2017) surveyed 179 service providers working with refugees in South Korea, and found that 51% exhibited high levels of STS, and that STS was significantly correlated with burnout in this population.

There are significant psychological effects of STS or VT and burnout, including depression, anxiety, intrusive imagery, relational difficulties, and changes in world view (Akinsulure-Smith, 2012; Koutsimani et al., 2019; Palm et al., 2004; Roberts et al., 2021; Zivanovic & Markovic, 2020). Thus, providers working with refugees may experience a range of mental health concerns due to their work with refugee populations. Because burnout is so highly correlated with ineffective work performance, absenteeism, and attrition (Maslach & Jackson, 1981; O'Connor et al., 2018; Roberts et al., 2021), examining the experiences of burnout in providers who work directly with refugees is essential in order to provide effective care for this population, and, in turn, the displaced populations they serve.

The Experience of Burnout

Burnout was first introduced as a concept by Freudenberger in the early 1970s after he noticed a specific set of symptoms including irritability and emotional exhaustion among staff at a mental health clinic for underserved populations that he helped develop in New York (Freudenberger, 1973). This concept was further refined in the 1980s by Christina Maslach, who eventually developed the Maslach Burnout Inventory (MBI), a widely recognized tool for measuring burnout across many professions (Maslach & Jackson, 1981; Maslach, 2017; Kavan & Powell, 2021). Maslach described burnout as a psychological syndrome resulting from prolonged exposure to job-related stress with three dimensions: (a) exhaustion (physical and emotional), (b) cynicism/depersonalization and detachment from clients, and (c) a sense of personal ineffectiveness (De Hert, 2020; Maslach, 2017; Maslach & Jackson, 1981; Maslach & Leiter, 2017). Burnout can manifest in any profession, however, individuals working in 'helping' professions, such as mental health care and social services, are at higher risk due to the unique demands of the therapeutic relationship (Maslach, 2003; O'Connor et al., 2018). Indeed, professionals who work with displaced populations such as refugees often report very high levels of burnout (Roberts et al., 2021; Sagaltici et al., 2022).

Burnout has been described as "not a problem of people but of the social environment in which they work" (Maslach & Leiter, 2017, p. 160). The organizational structure of the workplace and the health of workplace relationships are key components of burnout (De Hert, 2020; Maslach & Leiter, 2017). In addition, the risk of burnout increases when there is a mismatch between an individual's basic human needs, such as belonging, efficacy, and emotional safety, and their job (Maslach, 2017; Maslach & Leiter, 2017). A thorough understanding of the three dimensions of burnout can shed light on the experience of refugee

service providers experiencing this syndrome, allowing more effective measures to mitigate its effects.

Three Dimensions of Burnout

When Freudenberger first conceptualized the syndrome of burnout in the 1970s, he developed a 12-stage model to describe its development, focusing on the symptoms of burnout (DeHert, 2020). Maslach built on the groundwork laid by Freudenberger, expanding the explanation of burnout as a multidimensional construct with three main dimensions: exhaustion, cynicism (depersonalization), and a sense of personal ineffectiveness (Maslach, 2003). This multidimensional model includes an individual's stress response to a demanding job experience (exhaustion), but goes beyond this individual experience to include an individual's response to their job (cynicism), and their response to themselves given the demands and stressors of their job situation (reduced sense of effectiveness) (Maslach, 2003; Maslach & Leiter, 2017).

The dimension of exhaustion has been described as a stress response when an individual's emotional resources are depleted (Maslach, 2003; Maslach & Jackson, 1981). In the exhaustion phase of burnout, a person experiences fatigue and is worn out and run down (Maslach, 2017; Maslach & Jackson, 1981; Maslach & Leiter, 2017). For example, individuals experiencing the exhaustion dimension of burnout may feel like they do not have a source of replenishment and are not sure they have what it takes to meet the demands of their job (Maslach, 2017; Maslach & Jackson, 1981; Maslach & Leiter, 2017). Exhaustion is seen as the basic stress response individuals experience when the demands of their job outweigh their capabilities or resources (Maslach, 2003). As such, even though the dimensions of burnout are not linear, exhaustion is often experienced first, prior to the other two dimensions (Maslach, 2003; Maslach & Leiter, 2017). Exhaustion is strongly correlated with cynicism (the second

dimension of burnout) as individuals often distance themselves from their work, detaching from aspects of their job, in order to attempt to manage feelings of overload during the exhaustion phase (Maslach, 2003; Maslach & Leiter, 2017).

The dimension of cynicism in burnout is sometimes referred to as “depersonalization”, describing an individual’s feelings of detachment from clients (De Hert, 2020; Maslach, 2017). Cynicism is seen as a coping mechanism in response to the exhaustion felt in the earliest phase of burnout (Maslach, 2003; Maslach & Leiter, 2017; O’Connor et al., 2018). The dimension of cynicism is characterized by negative feelings or critical attitudes toward clients, causing a person to distance themselves and become irritable and callous (Maslach, 2017; Maslach & Jackson, 1981; Maslach & Leiter, 2017; O’Connor et al., 2018). Often, cynicism serves a protective function at first, providing distance from emotional overload (Maslach & Leiter, 2017). However, over time it develops into a negative attitude that pervades an individual's work experience (Maslach & Leiter, 2017). Providers experiencing the detachment of cynicism often exhibit a negative, uncaring attitude toward those they work with, increasing the likelihood of decreased effectiveness or poor client care (DeHert, 2020; Maslach & Leiter, 2017).

Exhaustion and cynicism are often followed by a diminished sense of effectiveness in one’s job (Maslach, 2017; Maslach & Jackson, 1981; Maslach & Leiter, 2017; O’Connor et al., 2018). In this third dimension of burnout, personal ineffectiveness, individuals feel incompetent and often question their achievements (Maslach & Leiter, 2017). In this phase, lack of motivation, questioning one’s career choices, and depression are often evident (DeHert, 2020; Maslach & Leiter, 2017). Simply stated, burnout often begins with exhaustion based on job stressors, moves to cynicism in which a person copes by distancing and creating negative views of clients, and results in feelings of failure and inefficacy (Maslach & Jackson, 1981; Maslach &

Leither, 2017). The experience of burnout is profound as Maslach stated, “Instead of healthcare work bringing the greatest satisfaction, fulfillment, and confirmation of one’s identity, work becomes a joyless burden to be minimized, avoided and escaped” (Maslach & Leiter, 2017, p. 161).

Burnout in Helping Professions

Although burnout can occur in any profession, the concept was originally identified in helping professions (Maslach, 2015). In fact, when individuals work with clients whose needs require high emotional engagement, the risk for burnout increases (Maslach, 2015; Maslach & Leiter, 2017; Morse et al., 2012). Burnout has been documented in individuals working in many helping professions, such as nurses, physicians, teachers, and mental health providers (De Hert, 2020; Gabassi et al., 2002; Paris & Hoge, 2009; Morse et al., 2012). Mental health workers appear to be uniquely at risk for burnout due to their constant exposure to suffering, crisis, or trauma, leading to high levels of attrition and turnover among mental health professionals, high cost of hiring and training staff, and poor client outcomes (Paris & Hoge, 2009; Morse et al., 2012). However, while burnout remains a major concern for social service providers in general, it is especially salient for providers working with refugees due to the inherent exposure to high levels of trauma (Kim, 2017; Roberts et al., 2021).

Experiences of Burnout in Providers Who Work with Refugees

Although the literature examining the experience of burnout among service providers serving refugee populations is limited, existing research indicates that this population is at high risk for burnout due to secondary traumatization (Akinsulure-Smith et al., 2018; Sifaki-Pistolla et al., 2017). In fact, Akinsulure-Smith et al. (2018) surveyed 210 refugee resettlement workers across six different refugee-resettlement agencies (RRAs) in the United States, and not only

found high levels of STS and burnout among providers, but also determined a strong correlation between these two variables. Similarly, a 2022 study that surveyed 199 direct service workers providing care to refugees in Turkey found that 40% reported high levels of emotional exhaustion (the first dimension of burnout), and 19% experienced high levels of depersonalization (the second dimension of burnout) (Sagaltici et al., 2022). In yet another study, Chatzea et al. (2018) surveyed 217 rescue workers employed by five different refugee service organizations in Greece and found that 57% of participants reported experiencing high levels of burnout. In addition, a 2021 systematic review by Roberts et al. analyzing 15 studies on providers working with refugees globally revealed that approximately 30% of participants reported high levels of burnout. These findings collectively highlight the significant prevalence of burnout among providers working directly with refugee populations.

When providers who work with refugees experience burnout, the quality of care they provide to the populations they serve can be significantly affected or even compromised (Akinsulure-Smith et al., 2018; Kavukcu et al., 2019; Kim, 2017). In fact, research indicates that burnout poses a significant threat to the well-being of these providers, often leading to attrition and poor client care (Ager et al., 2012; Kim, 2017; Kavukcu et al., 2019). Thus, as the numbers of refugees fleeing untenable situations in their home countries continue to rise daily (UNHCR, 2024), the role of direct service workers becomes increasingly vital to deliver essential support to this unprecedented influx of displaced individuals. Indeed, the mental health needs of both refugees and their service providers are equally critical. Understanding and addressing the issue of burnout is essential for enhancing the well-being of refugee service providers, thereby enabling them to provide effective care to victims of forced displacement. The impact of burnout

on providers working with refugees can be understood through existing theoretical perspectives on the health of workplace systems, specifically Bowen Family Systems Theory (BFST).

Theoretical Foundation – Bowen Family Systems Theory

A Systemic Approach

Early research into the syndrome of burnout focused mostly on individual factors that led to symptoms (Maslach, 2003; Maslach, 2017; Maslach & Leiter, 2017). As a result, the solutions proposed have heavily focused on individual interventions, such as coping strategies or stress management techniques (Maslach, 2017). However, an individualistic approach alone is not effective in managing the sources of stressors in the workplace (Maslach, 2003; Maslach, 2017; Montgomery et al., 2019). Indeed, research has suggested that effective approaches to addressing burnout must consider workplace systems as a whole, rather than focusing solely on the individuals within them (Maslach, 2003; Maslach, 2017; Montgomery et al., 2019). Although less researched, addressing systemic issues, rather than individual issues alone, is regarded as a more effective long-term approach to burnout (Leiter & Maslach, 2014). A systems theory, in this case, Bowen Family Systems Theory (BFST), which focuses not just on families but also on workplace and societal systems, provides a helpful framework through which to explore the issue of burnout among providers working with refugees.

BFST is a theory of human behavior developed by Murray Bowen, first published in the 1960s (Gilbert, 2004). BFST conceptualizes systems as emotional units in which the experiences and emotions of one member affect all other members (Kerr & Bowen, 1988). BFST emphasizes the dynamic interplay between two core processes within any system: the forces of togetherness (representing the system's collective needs), and differentiation (reflecting the individual's unique needs) (Papero, 2017). These concepts underscore that every system is composed of

individuals with varying degrees of differentiation, coexisting within a system that may itself exhibit high or low levels of differentiation (Papero, 2017; Skowron & Friedlander, 1998).

At its core, differentiation refers to two interrelated dimensions: (a) an individual's ability to distinguish between emotions and thoughts, and hold them in balance, especially in stressful situations, and (b) an individual's ability to maintain a balance between autonomy and intimacy in personal relationships (Halevi & Idisis, 2018; Rizkalla & Segal, 2019; Skowron & Friedlander, 1998). The ability to regulate emotions, manage anxiety, and maintain objectivity, even when others are anxious, is a key feature of differentiation, and it is predictive of higher levels of psychological functioning (Kerr & Bowen, 1988). A system is made up of individuals with varying levels of differentiation, and the system's overall level of differentiation reflects the collective ability of its members to manage emotional intensity and maintain individuality while also maintaining connection (Kerr & Bowen, 1988). Thus, a system that is poorly differentiated will present with more reactivity in response to problems, along with increased pressure on individual members to absorb the system's anxiety and to rely on one another's emotional responses for validation and stability (Papero, 2017). In fact, according to BFST, the emotional functioning of members of a system is profoundly interrelated (Kerr & Bowen, 1988). Therefore, the health of both an individual and the system in which they exist need to be considered in order to increase emotion regulation and effective functioning (Papero, 2017; Skowron & Friedlander, 1998).

Bowen envisioned his theory as applying to the family, but also to other systems individuals belong to, including the workplace (Chambers, 2009; Gilbert, 2004; Kerr & Bowen, 1988). He argued that the same dynamics that govern how family systems function apply to workplace dynamics as well (Chambers, 2009). For example, individuals display similar levels

of differentiation and emotional reactivity at home and in the workplace (Gilbert, 2004). Like families, signs of poor functioning in a work system include high levels of anxiety or tension, an increase in emotional intensity, and a decline in independence and autonomy (Papero, 2017). Systems that are functioning effectively are characterized by higher levels of flexibility, greater ability to manage stress, and greater ability to solve problems (Skowron & Friedlander, 1998).

BFST posits that even poorly differentiated systems can function well during times of low stress (Kerr & Bowen, 1988). However, when systems are subjected to increased stress, less differentiated individuals within the system are more likely to respond with anxiety and reactivity, affecting the functioning of the whole system (Kerr & Bowen, 1988; Papero, 2017). When applying a BFST framework to systems defined by high levels of trauma exposure, such as refugee service organizations, the entire system is subjected to potential dysfunction and is at risk of poor functioning (Papero, 2017). An understanding of differentiation of self, an essential tenet of BFST, is necessary to accurately conceptualize the experience of providers working with refugees within the workplace system.

Differentiation of Self

Differentiation of self is arguably the most important construct of BFST (Bowen, 1985; Gilbert, 2004; Skowron & Friedlander, 1998; Titelman, 1998; Winek, 2010) and is also the most researched. For example, higher levels of differentiation have been shown to be positively correlated with self-efficacy in a population of 393 Jewish and Arab students (Peleg & Idan-Biton, 2018). In addition, in a 2002 study of 117 college students in Israel, lower differentiation levels were significantly associated with higher levels of social anxiety (Peleg-Popko, 2002). Beebe and Frisch (2009) conducted a study on a sample of nurses in the United States, finding that those with higher levels of differentiation experienced lower levels of burnout, specifically

the emotional exhaustion dimension (Beebe & Frisch, 2009). In 2018, Halevi and Idisis studied a group of 134 mental health clinicians in Israel, and found that higher levels of differentiation of self correlated strongly with lower levels of VT. Interestingly, differentiation of self is the only BFST tenet to be researched specifically regarding refugee trauma work (Rizkalla & Segal, 2019). Specifically, Rizkalla and Segal (2019) found that lower self-differentiation was associated with higher levels of STS and lower wellbeing among service providers working with Syrian refugees in Jordan.

From a BFST lens, understanding the interplay between individual and systemic levels of differentiation is essential for assessing the health of a workplace system (Chambers, 2009; Gilbert, 2004). In workplace settings, differentiation operates on two interconnected levels: individual differentiation, which relates to an individual worker's ability to self-regulate and maintain identity, and systemic differentiation, reflecting the organization's collective capacity to foster independent yet interconnected roles (Chambers, 2009; Papero, 2017). According to Bowen, a healthy functioning system will be comprised of individuals with high levels of differentiation who are able to engage in effective, non-reactive problem-solving and healthy communication (Chambers, 2009; Kerr & Bowen, 1988).

BFST, and specifically the concept of differentiation of self, is a useful lens through which to examine burnout among providers who work with refugees. Specifically, BFST highlights how systems, as well as the individuals within them, adapt to and manage stress (Kerr & Bowen, 1988). Thus, it is a strong framework through which to consider the syndrome of burnout, which highlights the deleterious impact on workers' functioning when systems are highly stressed (Maslach, 2017). Utilizing a BFST framework to assess burnout incorporates both individual and systemic factors, offering a more comprehensive perspective on the issue.

This approach underscores the importance of considering how both personal and systemic influences may impact burnout levels among refugee service providers.

Factors Associated with Burnout Among Providers

There is a growing body of research examining the factors that impact the experience of burnout among providers who work with refugees. Among them are coping strategies, personal trauma history, and perception of organizational support.

Coping Strategies

Coping, defined as efforts to manage stressful demands (Akinsulure-Smith et al., 2018), has been researched regarding its effectiveness in mitigating the effects of burnout among refugee service providers (Akinsulure-Smith et al., 2018; Espinosa et al., 2019). Unhealthy coping mechanisms, such as self-blame, substance abuse, or denial, have been associated with burnout among professionals working with refugees (Akinsulure-Smith et al., 2018; Espinosa et al., 2019). However, healthy coping mechanisms, such as emotional support, positive framing, and acceptance, have been shown to mitigate the effects of burnout in this population (Akinsulure-Smith et al., 2018; Espinosa et al., 2019; Wathen et al., 2022). In fact, Espinosa et al. (2019) surveyed 210 refugee service workers across six refugee resettlement agencies in the United States and found that a reduction in unhealthy coping behaviors resulted in lower levels of burnout. Similarly, in a survey of 210 refugee service workers, Akinsulure-Smith et al. (2018) found that negative coping strategies were correlated with higher levels of burnout. Thus, it appears that investigating coping mechanisms is important in the study of burnout among providers who work with refugees.

Personal Trauma History

A personal trauma history has been linked to burnout across various populations. For instance, a 2014 study by Mather et al. identified a significant correlation between a personal history of trauma and burnout, based on data from a sample of over 25,000 twins in Sweden. Similarly, research by Kim et al. (2019) involving 535 firefighters in Korea revealed a strong relationship between trauma history and burnout. These findings suggest that a personal history of trauma increases the deleterious impact of refugee service work, heightening the risk of burnout. However, other research has been mixed, finding a connection between a personal history of trauma and secondary traumatic stress, but not burnout (Akinsulure-Smith et al., 2018; Leung et al., 2023). Therefore, gaining a deeper knowledge of the impact of a personal trauma history on burnout in this population will assist in supporting the individual's emotional functioning and improving the broader systems in which they work.

Organizational Support

Finally, the health of an individual's work environment appears to be a very important factor influencing the experience of burnout among those serving refugees (Eriksson et al., 2009; Kim, 2017). For example, caseload levels that are unmanageable and lack of resources are shown to be highly correlated with burnout in these settings (Kim, 2017). In addition, in 2009 Eriksson et al. conducted a study examining the experiences of refugee service providers from 34 different countries employed at an international humanitarian aid organization, finding a significant relationship between perceived organizational support and burnout, with lower perceived organizational support linked to increased burnout. This finding was further substantiated by Kim (2017) in a study of 230 refugee service providers in South Korea, in which low levels of perceived organizational support were also found to be significantly correlated with higher levels

of burnout. These findings underscore the importance of organizational support in mitigating burnout among refugee service providers. Thus, examining perceptions of organizational support is important for understanding and addressing the factors contributing to burnout in this population, ultimately promoting better mental wellbeing for providers and the refugees they serve.

Differentiation of Self and Burnout

In addition to aforementioned variables, scholars have examined the impact of differentiation of self on an individual's functioning in the workplace, specifically their experience of burnout (Beebe, 2007; Beebe & Frisch, 2009; Mroz & Kaleta, 2015). In fact, in a 2007 study surveying 343 clergypersons in New York, higher levels of differentiation predicted lower levels of burnout (Beebe, 2007). Similarly, another study examining differentiation levels among 72 practicing nurses found that higher levels of differentiation were correlated with lower levels of burnout as well as a greater ability to emotionally disengage from stressful events in the workplace (Beebe & Frisch, 2009). In addition, Yavuz-Guler (2023) surveyed 346 working adults in Turkey regarding their workplace experiences and determined a negative correlation between differentiation of self and burnout.

While research has established a relationship between differentiation of self and burnout among various populations, studies specifically examining differentiation of self among refugee service providers remain scarce and do not address the phenomenon of burnout. One existing study suggests that lower levels of differentiation among providers are associated with higher levels of STS (Rizkalla & Segal, 2019). However, a connection between burnout and differentiation of self in this population has not been explored, exposing a significant gap in research. Applying a BFST framework to burnout suggests the inclusion of differentiation of self

in order to gain vital insight into the individual and systemic characteristics that may be contributing to this phenomenon among providers.

Purpose of the Study

BFST, and particularly the concept of differentiation of self, provides a valuable framework from which to consider the factors related to burnout among refugee service providers. This study explores key variables identified in the literature that are associated with burnout (i.e., coping mechanisms, personal trauma history, perceptions of organizational support), while introducing differentiation of self as an additional factor, which has not yet been studied in relation to burnout within this population. The goal of this study is twofold: to provide clinicians with insights to better address the counseling needs of refugee service providers, and to inform agency directors and policymakers in developing healthier organizational systems to support the critical work of refugee resettlement.

Research Significance

While there is a growing body of research examining the experiences of burnout in human services fields, there is limited research regarding burnout among providers who work with refugees (Akinsulure-Smith et al., 2018). In addition, the research that does exist often investigates the experiences of providers in other countries (Birger et al., 2020; Kim, 2017; Mesa et al., 2020; Posselt et al., 2019), pointing to the need for more research into this population in the United States (Akinsulure-Smith et al., 2018). Furthermore, the overwhelming demand for services in the current forced migration crisis has overtaxed systems, thus contributing to organizational issues that may lead to burnout (Posselt et al., 2019; Rizkalla & Segal, 2020). Consequently, burnout among providers who work with refugees may contribute to the current global refugee crisis by preventing effective, quality care by trained staff and volunteers, leaving

the needs in this population unmet (Akinsulure-Smith et al., 2018; Gemignani et al., 2020; Wirth et al., 2019).

Currently, one study exists that specifically assessed related predictors of burnout among refugee service providers in the U.S. Akinsulure-Smith et al. (2018) conducted a study among 210 participants from six RRAs in the United States and focused on the influence of coping, trauma history, and emotional intelligence on STS and burnout. Findings from this study highlighted high levels of burnout among refugee service providers and the potential for healthy coping behaviors and emotional intelligence to mitigate its effects. Building on this research, the present study seeks to further examine burnout among refugee service providers in the United States through the lens of BFST. Specifically, it will investigate factors already associated with burnout in existing literature (i.e., coping mechanisms, personal trauma history, perceptions of organizational support) but will also offer a distinct focus on the impact of differentiation of self on burnout, a perspective that has not yet been examined in this population. In addition, while these three variables identified in the literature as predicting burnout among providers have been researched individually, they have not been analyzed simultaneously within a single predictive model. Investigating these four variables together within a predictive model explaining burnout allows for an exploration of their individual effects but also potential interactions between them, providing a more comprehensive, nuanced understanding of the complex realities of burnout.

Moreover, the current study includes more demographic variables with the aim of providing richer context to the findings, as well as improving generalizability. Building on established research, this study seeks to advance understanding of the relationship between differentiation of self and other identified factors on burnout among refugee service providers,

with an aim of equipping counselors and counselor educators to more effectively support these providers as they serve the needs of displaced individuals in the United States.

Purpose Statement and Research Question

The purpose of this study will be to examine the predictability of demographic characteristics, coping mechanisms, personal trauma history, perceived organizational support, and differentiation of self on burnout among providers who work directly with refugees in the United States. Specifically, this study will be guided by the following research question: Does differentiation of self explain a unique amount of variance of burnout among providers who work directly with refugees in the United States above and beyond known predictive factors (i.e., coping mechanisms, personal trauma history, and perception of organizational support) after controlling for demographic variables (i.e. gender, race/ethnicity, age, history of forced migration, and time on the job)? By identifying the factors that significantly predict burnout, counselors and policymakers may be better equipped to support providers working directly with refugees, and, subsequently, help them provide better care to the communities they are serving.

Chapter Summary

Refugees are resilient individuals whose circumstances have thrust them into extremely stressful, untenable, traumatic, and even life-threatening situations. Fleeing, while typically a last resort, is a necessary step taken to preserve both life and health. Fleeing, however, comes with its own set of stressors, and the needs of this population remain equally significant post-resettlement as they were prior to displacement. The extensive and ongoing needs of displaced populations are overwhelming the systems currently in place to support them. Meeting the needs of this marginalized and vulnerable group is complex and layered. In the United States, thousands of providers, both paid and volunteer, serve the resettled refugee population, assisting with their

educational, legal, medical, housing, and mental health needs. Their unique position with refugee populations exposes them to stories of horrific trauma and painful loss, increasing the risk of burnout. Refugee service workers often attempt to provide services to this traumatized population while operating within overburdened organizations with insufficient resources. The combination of organizational issues and the impact of STS often results in burnout in refugee service workers. Gaining a deeper understanding of the needs of this population holds significant implications for the counseling field, underscoring the importance of innovative approaches that address the unique stressors and challenges they encounter. Indeed, counselors and counselor educators must be better equipped to assist refugee service workers in particular with burnout, leading to more effective systems from which to meet the needs of the individuals they serve. Using a BFST framework is a unique and innovative approach to examining predictive factors of burnout in refugee service providers and could lead to more effective long-term solutions that enhance the wellbeing and professional performance of this population. A systems approach requires addressing both the needs of individuals as well as the organizational systems in which they operate. Thus, the aim of this study is to provide counselors, counselor educators, as well as policymakers and directors of refugee service organizations with systemic knowledge of what influences burnout among providers who work with refugees, which may lead to better support for these individuals.

CHAPTER 3

METHODOLOGY

The proposed study aimed to identify predictors of burnout among providers working directly with refugees in the United States utilizing a Bowen Family Systems Theory (BFST) framework. In this chapter, readers will find a description of the research question and hypothesis, as well as the significance of the study. The chapter includes a thorough description of sampling procedures, eligibility criteria for participants, and the assessment instruments that comprised the research survey. In addition, readers will find detailed information regarding the research design, theoretical framework, procedures for data collection, data analysis methods, and limitations. The chapter concludes with an exploration of the potential implications of the findings for clinicians, counselor educators, policy makers and directors of refugee organizations, offering insights to inform clinical practice, guide policy making, and shape future research.

Research Question and Hypothesis

This study was designed to investigate the following research question: Does differentiation of self explain a unique amount of variance of burnout among providers who work directly with refugees in the United States above and beyond known predictive factors (i.e., coping mechanisms, personal trauma history, and perception of organizational support) after controlling for demographic variables (i.e. age, gender, and history of forced migration)?

Based on a review of the literature, this study endorsed the following hypothesis:

the full regression model will significantly explain the variance of burnout among providers who provide direct support for refugees, with the variable of interest in Step 3 (differentiation of self) explaining variance above and beyond Step 2 (coping strategies, personal trauma history, and perception of organizational support) and Step 1 (age, gender, and history of forced migration). Although variables based on prior research (i.e., coping mechanisms, personal history of trauma, and perception of organizational support) were expected to account for some variance in burnout among refugee service providers, it was hypothesized that differentiation of self would explain unique variance above and beyond these predictors. Specifically, as differentiation of self scores increase, burnout scores were expected to decrease.

Research Significance

Due to the high risk of burnout among refugee service providers (Ager et al., 2012; Roberts et al., 2021), along with its association with significant psychological distress, increased staff attrition, and poor client care (Morse et al., 2012), it is important to investigate factors that contribute to this phenomenon. Previous researchers have identified several predictors of burnout in this population, including the use of negative coping mechanisms (Espinosa et al., 2018) inadequate organizational support (Eriksson et al., 2009), and a personal history of trauma (Akinsulure-Smith et al., 2018). Additionally, low levels of differentiation of self (Rizkalla & Segal, 2019) have been recognized as a significant contributor to burnout, however this connection has not been studied in refugee service providers specifically.

A review of the literature revealed a gap in research examining the predictive role of differentiation of self in relation to burnout in refugee service providers in the United States. In addition, no research to date has examined coping mechanisms, personal trauma history, and perception of organizational support, simultaneously within the same model in relation to

burnout in this population. Furthermore, previous studies have not employed a BFST framework to understanding burnout, which facilitated an analysis of both individual and systemic factors in this study. A concurrent analysis of these variables among refugee service providers, viewed through a BFST framework, intended to shed light on the dynamic interactions among factors contributing to burnout while also clarifying the distinct impact of each factor.

Theoretical Framework

The theoretical framework guiding this study is BFST, a systems theory of human behavior that explains functioning in any human system, including the workplace (Chambers, 2009; Gilbert, 2004). BFST posits that an individual's level of differentiation is predictive of psychological functioning, both for the individual and for any system of which they are a member (Papero, 2017). Differentiation refers to an individual's ability to maintain a clear sense of self, while also remaining emotionally connected to others (Kerr & Bowen, 1988; Papero, 2017). In the workplace this involves balancing individual needs with professional engagement, allowing individuals to maintain their emotional responses without being overly influenced by workplace stressors or others' emotions (Chambers, 2009; Papero, 2017). Low differentiation can lead to reactive emotional responses and poor ability to manage stress in healthy ways, which may contribute to burnout (Rizkalla & Segal, 2020). This study aimed to utilize a BFST framework, specifically the construct of differentiation of self, to examine burnout among refugee service providers, adding to the literature by providing a unique approach which may lead to innovative solutions.

Research Design

This study employed a quantitative, cross-sectional, predictive research design to examine the relationships between variables and the extent to which the selected variables

predict one criterion variable based on data collected from participants at one point in time (Palmer & O'Connell, 2009). Given the goal of this study to provide generalizable data regarding relationships between the variables, a quantitative method was most appropriate (Balkin & Kleist, 2016). A regression model is the best approach to answer this research question as it allows for an investigation into the predictive nature of the relationship between one dependent variable (DV) and one or more independent variables (IVs; Balkin & Kleist, 2016).

This study specifically used a hierarchical regression model, in which a series of linear regression analyses are performed in order to determine how much each variable contributes to differences in the DV (Pedhazur & Kerlinger, 1982). A simple linear regression model examines how one IV predicts values of one DV (Pedhazur & Kerlinger, 1982). A multiple regression expands on a simple regression model and examines how the variance in DV values is explained and predicted by more than one IV (Pedhazur & Kerlinger, 1982). A hierarchical regression model is a specific form of multiple regression in which each IV (or set of IVs) is entered in a specific order based on theory, allowing the researcher to determine how much variance in the DV is explained by each IV (or set of IVs) after accounting for the variance in previous steps (de Jong, 1998; Pedhazur & Kerlinger, 1982). When variables are selected based on their theoretical importance, a hierarchical regression model should be favored (De Jong, 2009; Field, 2018). Therefore, a hierarchical multiple regression analysis was the best approach for this study as the IVs are conceptually correlated, theoretically grouped into steps, and the model accounts for shared variance while isolating the specific effect of each IV (Lindenberger & Potter, 1998).

Participants and Procedures

Participants were recruited from Refugee Resettlement Agencies (RRAs) and affiliated organizations. This study utilized a combination of convenience and snowball sampling through

the use of contact lists specific to staff employed or volunteering at these agencies. Email addresses of providers were obtained through professional networks, as well as publicly available contact information for staff associated with RRAs and affiliated organizations. Recruitment emails were sent to eligible staff and volunteers, including social workers, case managers, therapists, medical personnel, employment counselors, academic tutors, translators, legal service providers, and volunteers who directly interact with refugees. Additionally, recipients were encouraged to share the recruitment email with others who may qualify and be interested in participating.

A statistical a priori analysis through the G*Power program was used to determine the appropriate sample size. A sample size of 92 was required, using a .05 alpha level, a medium effect size of .15, and .80 power, based on five tested predictors (BriefCOPE [healthy coping and unhealthy coping], Life Events Checklist [LEC-5], Perceived Organizational Support [POS-8]), Brief Differentiation of Self Inventory (Brief DSI), and eight total predictors (which consisted of dummy coded demographic variables). To participate, providers and volunteers needed to be at least 18 years of age, living in the United States, and engaged in paid or volunteer work with an RRA or one of the many local affiliates contracted by RRAs. Participants must have held their positions for a minimum of one year and have regular, direct contact with their refugee clientele on a weekly basis. Specifically, regular direct contact was defined as an average of at least three hours per week of in-person or virtual interaction with refugees seeking assistance in any aspect of the resettlement process. Eligible participants included individuals involved in various components of resettlement, provided they deliver social services, such as legal assistance, medical or mental health care, language and employment assistance, case management, or other related services.

Prior to sending my recruitment email, I obtained approval from the university's Institutional Review Board to conduct this study. Upon receiving approval, email was used to distribute the study invitation, along with an informed consent form, to individuals who met the eligibility criteria for participation. Data was collected via Qualtrics, an online survey program. The recruitment email provided an overview of the study and included a link to the survey. The first page of the survey presented an informed consent form that outlined the study details, explained an incentive for participating, and described any potential risks associated with involvement. Specifically, participants were informed that the first 125 participants would receive a $10 gift card via email upon completion of the survey. To receive the incentive, participants were asked to provide their email address; however, they were reminded that their survey responses would remain anonymous. The survey consisted of 101 questions and took approximately 20 minutes to complete. Once participants completed the survey, they submitted it online via Qualtrics, where responses were stored in a confidential manner with access restricted to the researcher.

Instrumentation

This study utilized the following instrumentation: (a) the Copenhagen Burnout Inventory (CBI; Kristensen et al., 2005), (b) the BriefCOPE questionnaire (Carver, 1997), (c) the Life Events Checklist (LEC-5; Weathers et al., 2013), (d) the Perceived Organizational Support Scale (POS-8; Eisenberger et al., 1986), (e) the Brief Differentiation of Self Inventory(Brief DSI; Sloan & van Dierendonck, 2016), and (f) a demographic questionnaire.

Demographics Questionnaire

A questionnaire comprised of nine items was used to collect demographic data from participants. Demographic identifiers specific to this study included gender, race/ethnicity,

religious/spiritual affiliation, education level, age, specific role or position in the agency, frequency of interaction with refugees, personal history of forced migration, and time on the job. Many of these items were used to describe the sample, yet some also served as control variables in the first step of the regression model (i.e., gender, age, and history of forced migration) to measure their potential significance in explaining the variance of burnout.

Copenhagen Burnout Inventory (CBI)

Burnout was measured using the Copenhagen Burnout Inventory (CBI; Kristensen et al., 2005). The CBI consists of 19 items resulting in three subscales: Personal Burnout (six items), Work-related Burnout (seven items), and Client-related Burnout (six items) (Kristensen et al., 2005). Example items include "*How often are you emotionally exhausted?*" (from the Personal Burnout subscale), "*Are you exhausted in the morning at the thought of another day at work?*" (from the Work-related Burnout subscale), and "*Do you sometimes wonder how long you will be able to continue working with clients?*" (from the Client-related Burnout subscale). Respondents answer using a five-point Likert-type scale that varies with the specific questions. For example, the Personal Burnout subscale, the last four questions of the Work-related Burnout subscale, and the last two questions of the Client-related Burnout subscale are scored as 1=*never/almost never*, 2=*seldom*, 3= *sometimes*, 4= *often*, and 5=*always*. The first three questions of the Work-Related Burnout subscale and the first four questions of the Client-related Burnout subscale are scored as 1=*to a very low degree*, 2=*to a low degree*, 3=*somewhat*, 4=*to a high degree*, and 5=*to a very high degree*. Scores for each item on all three subscales are translated into scores of 0 (*never/to a very low degree*), 25 (*seldom/to a low degree*), 50 (*sometimes/somewhat*), 75 (*often/to a high degree*), and 100 (*always/to a very high degree*). Scores for each subscale are then averaged and can also be aggregated into a total score. Higher scores indicate a higher level of burnout

(Kristensen et al., 2005; Montgomery et al., 2020). Previous research has demonstrated that the CBI has adequate construct and convergent validity (Montgomery et al., 2020). Additionally, a 2018 study demonstrated that the CBI exhibits strong reliability in assessing global burnout, with the total score derived by aggregating the scores across the three subscales. The study reported a Cronbach's alpha of .90, indicating high internal consistency (Lapa et al., 2018).

BriefCOPE

Coping strategies were measured using the BriefCOPE questionnaire, adapted from the COPE (Coping Orientation to Problems Experienced) (Carver, 1997; Carver et al., 1989). The BriefCOPE is one of the most frequently used instruments to measure coping responses (Garcia et al., 2018). Coping mechanisms listed in the measure are categorized as healthy *("I've been getting emotional support from others"*) and unhealthy *("I've been using alcohol or other drugs to make myself feel better"*). Respondents are asked to indicate how often they engage in each coping mechanism listed within the past month, with the following responses available: 1=*I haven't been doing this at all, 2 = A little bit, 3 = A medium amount* or *4 = I've been doing this a lot.* This 28-item instrument generates three subscales indicating three different coping styles: problem-focused coping, emotion-focused coping, and avoidance coping (Hegarty & Buchanan, 2021). These scales can be combined into two composite scales: healthy coping (which includes items from the emotion-focused coping subscale and problem-focused coping subscale), and unhealthy coping (which includes items from the avoidance coping subscale) to measure adaptive or maladaptive coping behaviors (Espinosa et al., 2019). Scores are summed for each composite scale, with higher numbers indicating higher levels of healthy or unhealthy coping (Hegarty & Buchanan, 2021). A 2018 study reported Cronbach's alpha values of .79 for scores on the healthy coping subscale and .70 for scores on the unhealthy coping subscale, indicating

acceptable reliability (Espinosa et al., 2019). Construct validity has also been supported in several studies (Akinsulure-Smith et al., 2018; Carver, 1997; Garcia et al., 2018; Haladay & Cook-Cottone, 2023). This study utilized two composite scales from this instrument: healthy and unhealthy coping.

Life Events Checklist (LEC)

The Life Events Checklist (LEC-5; Weathers et al., 2013) was used to measure personal trauma history. This instrument is widely used to determine exposure to traumatic events over one's lifetime and has been used previously in research regarding the experiences of providers working with refugees (Akinsulure-Smith et al., 2012). The questions in the LEC-5 are designed to evaluate experiences of events that could lead to PTSD or trauma symptoms, such as exposure to a war zone, or being physically assaulted. Respondents are asked to respond to 17 items, considering their entire life, indicating whether they have: *directly experienced a particular traumatic event, witnessed it, learned about it, experienced it vicariously as part of a job,* is *not sure,* or *does not apply* (Weathers et al., 2013). A score of one is applied to any response that indicates that a respondent has *directly experienced* a traumatic event, *witnessed it, learned about it*, or *was exposed to it as part of their job*. Any responses in the *not sure* or *does not apply* category are given a score of zero. Scores from the *happened to me, witnessed it, learned about it* and *experienced it vicariously as part of my job* are summed to yield a total score indicating the level of prior trauma history (Weis et al., 2022). A higher total score indicates greater exposure to trauma. Scores on the LEC-5 have demonstrated adequate reliability and validity across several studies (Akinsulure-Smith et al., 2012; Bae et al., 2008; Gray et al., 2004). Notably, a 2019 study by Espinosa et al. reported Cronbach's alpha of .75 for LEC-5 scores, reflecting acceptable internal consistency. Additionally, the LEC-5 has exhibited strong convergent validity

when compared to other established measures of trauma history, such as the Trauma Life Events Questionnaire (TLEQ; Gray et al., 2004).

Perceived Organizational Support Scale (POS-8)

Perception of organizational support was assessed using the Perceived Organizational Support Scale (POS-8), a short, eight item version of the original Perceived Organizational Support measure (Eisenberger et al., 1986; Eisenberger et al., 1997). The POS-8 measures respondents' perception of support they receive from their workplace, specifically, whether the organization values their well-being and shows concern for their experience (Eisenberger et al., 1997; Jin & Tang, 2021; Maan et al., 2020). Example items from the POS-8 include "*My organization really cares about my well-being*" and "*Help is available from my organization when I have a problem*" (Eisenberger et al., 1997). Respondents are directed to respond to each item based on a five-point Likert-type scale, with 1=*strongly disagree* and 5=*strongly agree*. Scores for the eight items are summed to yield a total score. A higher score indicates a higher perception of support as reported by the respondent. Scores on the POS-8 have demonstrated strong reliability across several studies, with a Cronbach's alpha of .88 (Maan et al., 2020) and .90 (Eisenberger et al., 1997).

Brief Differentiation of Self Inventory

Differentiation of Self was measured utilizing the Brief Differentiation of Self Inventory (Brief DSI; Sloan & van Dierendonck, 2016), a 20-item scale adapted from the Differentiation of Self Inventory-Revised (Skowron & Schmitt, 2003). The Brief DSI measures an individual's level of differentiation by examining four categories: Emotional Cutoff (EC), Emotional Reactivity (ER), I-position (IP), and Fusion with Others (FO) (Sloan & van Dierendonck, 2016). The EC subscale assesses the extent to which an individual distances themselves from others in

order to regulate relational anxiety, as illustrated by the item, *"When one of my relationships becomes very intense, I feel the urge to run away from it"*. ER evaluates an individual's ability to remain calm in response to the emotional expressions of others in a relational system, with an example item being, *"At times, my feelings get the best of me, and I have trouble thinking clearly"*. The IP subscale measures an individual's capacity to adhere to personal beliefs and values even when feeling external pressure, as reflected in the item, *"When I am having an argument with someone, I can separate my thoughts about the issue from my feelings about the person"*. Lastly, the FO subscale reflects the degree to which an individual experiences blurred boundaries with others, relying on them for identity formation and development of opinions, exemplified by the item, *"I feel a need for approval from virtually everyone in my life"* (Sloan & van Dierendonck, 2016). Respondents are asked to indicate how true each item is for them personally based on a Likert-type scale where 6 = *very* and 1 = *not at all*. Subscale scores are summed and can be aggregated into a total score. Higher scores on the subscales, as well as a higher total score, indicate higher levels of differentiation of self.

Scores on the full scale as well as the four subscales on the Brief DSI were found to have adequate reliability with Cronbach's alpha scores of .90 (global scale), .76 (EC), .85 (ER), .70 (IP), and .76 (FO) (Sloan & van Dierendonck, 2016). In addition, the Brief DSI has exhibited strong construct and content validity in previous research (Sloan & van Dierendonck, 2016). The present study utilized a global score in the analysis process.

Data Analysis

A hierarchical multiple regression with three steps was used to answer the research question in this study with burnout as the dependent variable. Step 1 of the regression model included demographic variables, including gender, age, and history of forced migration.

Categorical variables (i.e. gender, and history of forced migration) were dummy coded, while age was treated as a continuous variable. This step determined the amount of variance in providers' burnout scores that is explained by demographic variables only. In Step 2 of the regression model, four predictor variables that previous researchers have associated with burnout in refugee service providers were added, including coping mechanisms (BriefCOPE; [healthy coping and unhealthy coping]), personal history of trauma (LEC-5), and perceived organizational support (POS-8). This step determined if previously identified predictor variables explained a statistically significant additional amount of variance in burnout after accounting for demographic variables. Finally, in Step 3 of the regression model, an additional predictor variable based on the BFST concept of differentiation of self was added (differentiation of self [Brief DSI]. The analyses determined whether differentiation of self explained a significant amount of variance in burnout above and beyond demographic predictors and previously identified variables (i.e., coping mechanisms, personal history of trauma, and perception of organizational support). At each step of the model, I examined the beta coefficients and their corresponding p-values to determine which predictor variables most strongly contributed to the explained variance.

I used SPSS v. 29 for the statistical analysis (IBM Corp, 2023). Prior to conducting the hierarchical multiple regression analysis, I determined the means and standard deviations of all study variables and performed a correlational analysis to examine the relationships among the variables. Additionally, I assessed key assumptions for the regression model, including linearity, independence of errors, normality of residuals, multicollinearity, and homoscedasticity, to ensure the robustness of the model (Field, 2018).

Potential Implications of the Results

This study sought to contribute valuable insights to the fields of counseling and counselor education by informing effective strategies for supporting refugee service providers affected by the unique demands of their roles. Specifically, counselors may be equipped to better identify burnout in this population, and to more accurately conceptualize the source of the burnout, allowing for more specifically targeted interventions. Furthermore, this study proposed to examine the experiences of providers in the United States, which is an under-studied population, in order to expand the knowledge base regarding burnout in this context. Additionally, results of this study may contribute to existing theories of burnout, highlighting unique factors specific to refugee service providers. From a practical standpoint, findings from this study may provide insights that could be used to improve training programs, better equipping providers to manage the intense demands of their work and potentially preventing burnout. Furthermore, the application of a BFST framework offers a unique perspective for counselors to develop interventions for this population while also highlighting systemic factors contributing to burnout, thereby expanding treatment options for affected providers.

Adding to the knowledge base regarding burnout among refugee service providers in the United States may highlight areas for further research, such as cross-cultural comparisons. In addition, it may encourage clinicians to integrate individual and systemic factors when considering burnout in this population. For example, clinicians assisting a provider with burnout might begin by evaluating the differentiation level of their workplace system. This initial assessment can inform targeted recommendations for enhancing individual coping mechanisms in alignment with systemic dynamics. These potential implications highlight the possibility for

this study to inform practice, as well as policy and even research, with the overall goal of improving the well-being of providers as they serve an exceptionally vulnerable population.

A Priori Limitations

This study was not without limitations. First of all, a cross-sectional design was used. Therefore, this study was not able to determine causality. Additionally, data was collected through self-report, which introduces the limitation that the accuracy of the responses cannot be independently verified. Convenience sampling was used to gather participants, limiting the generalizability of findings (Andrade, 2020). And finally, data was collected via an online platform, limiting its accessibility only to those who have access to the internet.

Chapter Summary

The purpose of this study was to explore how differentiation of self, coping mechanisms, personal trauma history, and perception of organizational support predict burnout in providers working directly with refugees in the United States, after controlling for demographic variables. I recruited a sample of 91 from RRAs and affiliated organizations that provide social services to refugees who have resettled in the United States, are at least 18 years old, and have been employed in their role for a minimum of one year. Data collection occurred via an online survey distributed via Qualtrics. The survey was comprised of the CBI, BriefCOPE, LEC-5, POS-8, Brief DSI, and a demographics questionnaire assessing gender, race/ethnicity, religious/spiritual affiliation, education level, age, specific role or position in the agency, frequency of interaction with refugees, personal history of forced migration, and time on the job. A three-step hierarchical multiple regression model was utilized to assess the unique variance explained in burnout by previously identified factors (i.e., coping mechanisms, personal trauma history, perception of

organizational support), and differentiation of self, after controlling for demographic variables. Potential implications of the findings include the development of enhanced counseling interventions for providers impacted by burnout, as well as the formulation of more informed policies and training programs for this population. Findings may also reveal systemic factors contributing to burnout and identify key areas for future research, further advancing the well-being of refugee service providers.

CHAPTER 4

RESULTS

This study explored potential predictors of burnout among refugee service providers in the United States. Specifically, using a hierarchical multiple regression model, I sought to examine the amount of variance in burnout among refugee service providers explained by three sets of predictor variables: (1) demographic factors (age, gender, and history of forced migration), (2) a unique combination of variables supported by prior research (coping mechanisms [healthy and unhealthy], personal history of trauma, and perceived organizational support), and (3) my primary variable of interest (differentiation of self). This chapter will describe the demographics of the sample, reliability coefficients for the scores of each assessment instrument used in the study, as well as the results of the preliminary and main analyses performed to test the research hypothesis.

Description of the Sample

A Qualtrics survey was distributed via email to refugee service organizations in Georgia and shared on listservs reaching refugee service providers across the United States. A reminder email was sent to two listservs at one and two weeks after the initial distribution. Data was collected over a period of four weeks in February and March of 2025. A total of 112 responses were recorded; however, if participants did not provide their age, or if they did not answer 10 or more questions in the survey, their responses were removed. Ultimately, I removed 21 responses, resulting in 91 completed survey responses included in the analyses. According to the G*Power analysis program (Faul et al., 2007), a sample size of 92 was required to yield results that

indicate .80 power, using a .05 alpha level, and medium effect size of .15. However, a post hoc power analysis utilizing G*Power indicated that a sample size of 91 yields a power of .797, which was deemed sufficient for this analysis.

The majority of participants were female (*n* = 70, 77%), while 21% were male (*n* = 18), and 2% identified as non-binary (*n* = 3). Regarding race/ethnicity, 44% of participants identified as White (*n* = 40), 14% Southeast Asian (*n* = 13), 11% Middle Eastern/North African (*n* = 10), 11% Black/African American (*n* = 10), 4% Hispanic/Latino (*n* = 4), 3% South Asian (*n* = 3), 3% East African (*n* = 3), and 1% Central African (*n* = 1). Six percent of respondents (*n* = 7) selected "Other" when indicating their race/ethnicity. While most respondents indicated they had not experienced forced migration (*n* = 71, 79%), 19 (21%) participants indicated that they had, with 1 (1%) participant indicating they would rather not say. See Table 1 for further demographic characteristics of participants.

Table 1

Demographic Data of Participants

Variable		**Frequency (*n*)**	**Percentage (%)**
Age			
	18-20	3	3.3
	21-30	23	25.3
	31-40	23	25.3
	41-50	24	26.4
	51-60	10	11.0
	60+	8	8.8
Time on Job			
	1 year	25	27.8
	2-5 years	32	35.6
	6-10 years	18	20.0
	11-20 years	13	14.4
	21+ years	2	2.2

Education Level			
	No formal education	1	1.1
	Primary education	2	2.2
	Secondary education	10	11.0
	Vocational/technical training	4	4.4
	Bachelor's degree	34	37.4
	Graduate or professional degree	40	44.0
Primary Role			
	Case Manager/Case Worker	17	18.9
	Medical provider	8	8.9
	Mental health provider	8	8.9
	Legal advisor/immigration support provider	1	1.1
	Advocacy/policy specialist	1	1.1
	Language support provider (interpreter/translator, ESL instructor)	7	7.8
	Education, housing or job specialist	12	13.3
	Director/executive leadership	9	10.0
	Cultural orientation specialist	1	1.1
	Other	27	28.9
Religion/Spirituality	Islam	13	14.1
	Hinduism	3	3.3
	Buddhism	0	0
	Judaism	2	2.2
	Atheism	8	8.7
	Christianity	57	62.0
	Other	10	10.9

Frequency of Contact with Refugee Clientele *	Daily	37	40.7
	Several times a week	23	25.3
	About once a week	14	15.4
	A few times a month	10	11.0
	About once a month	7	7.7

Note. $N = 91$
*Four participants selected more than one response to this question. The more conservative response was included in each case, and the second response was discarded.

Descriptive Statistics of Instruments

Participants completed an online Qualtrics survey consisting of the Copenhagen Burnout Inventory (CBI; Kristensen et al., 2005), the BriefCOPE questionnaire (Carver, 1997), the Life Events Checklist (LEC-5; Weathers et al., 2013), the Perceived Organizational Support Scale (POS-8; Eisenberger et al., 1986), the Brief Differentiation of Self Inventory (Brief DSI; Sloan & van Dierendonck, 2016), and a demographic questionnaire, with a total of 101 questions. Cronbach's alpha scores for each scale exceeded .70, the minimum threshold recommended for social science research (Field, 2018). The following Cronbach's alpha levels were determined for the scores on each scale: CBI: .93, BriefCOPE-Unhealthy: .75, BriefCOPE-Healthy: .88, LEC-5: .93, POS-8: .91, and Brief DSI: .82. The mean CBI score for the sample was 41.75 ($SD = 16.75$). Further descriptive statistics of the instruments are provided in Table 2.

Table 2

Descriptive Statistics of Survey Assessments

Instrument/Subscale	***M***	***SD***	**Cronbach's Alpha**	**# of Items**
CBI	41.75	16.75	.93	19
BriefCOPE-Unhealthy	1.86	.45	.75	12
BriefCOPE-Healthy	2.69	.60	.88	16
LEC-5	13.73	10.88	.93	17

POS-8	3.89	.96	.91	8
Brief DSI	4.31	.71	.82	20

Note. CBI = Copenhagen Burnout Inventory; BriefCOPE = Brief – Coping Orientation to Problems Experienced Inventory; LEC-5 = Life Events Checklist for DSM-5; POS-8 = Perceived Organizational Support Scale; Brief DSI = Brief Differentiation of Self Inventory

Preliminary Analysis

Correlations Between Variables

Prior to examining the primary research hypothesis, I conducted a correlation matrix to examine the relationships between all study variables (CBI, age, gender, history of forced migration, BriefCOPE [Healthy and Unhealthy subscales], LEC-5, POS-8, and Brief DSI). Two categorical variables, gender and history of forced migration, were dummy coded for the purposes of statistical analyses. Gender was recoded into a binary variable (0=male, 1=female), excluding participants who selected "non-binary" due to the small number of responses in this category. Similarly, history of forced migration was dummy coded (0 = no, 1 = yes), indicating whether participants had personally experienced forced migration. The correlation matrix showed statistically significant correlations between many variables, yet correlations were all less than .8, indicating multicollinearity was not a concern (Field, 2018).

Table 3

Correlation Matrix of All Study Variables

	CBI	Age	Gender	Forced Migration	BriefCOPE Healthy	BriefCOPE Unhealthy	LEC5	POS8	Brief DSI
CBI	1	-	-	-	-	-	-	-	-
Age	-.300**	1	-	-	-	-	-	-	-
Gender	.149	-.160	1	-	-	-	-	-	-
Forced Migration	-.252*	-.169	-.104	1	-	-	-	-	-
Healthy Cope	.023	.159	-.037	-.071	1	-	-	-	-

Unhealthy Cope	.366**	-.021	-.089	-.131	.410**	1	-	-	-
LEC-5	.364**	-.176	-.139	-.199	.035	.153	1	-	-
POS-8	-.307**	-.025	.017	-.006	.163	-.074	-.096	1	-
Brief DSI	-.368**	.259*	.058	.047	-.016	-.504**	-.094	.076	1

Note. CBI = Copenhagen Burnout Inventory; BriefCOPE Unhealthy = BriefCOPE Unhealthy Cope Subscale; BriefCOPE Healthy = BriefCOPE Healthy Cope Subscale; LEC-5 = Life Events Checklist; POS-8 = Perceived Organizational Support Scale; BRIEF DSI = Brief Differentiation of Self Inventory.
$N = 91$
$^{*}p < .05$. $^{**}p < .01$.

Significant correlations depicted in this matrix add important information regarding the factors associated with burnout among refugee service providers. For example, age demonstrated a significant negative correlation with burnout (r = -.300), indicating a medium effect size (Cohen, 1988). This indicates that levels of burnout decrease as age increases. Burnout was also significantly negatively correlated with history of forced migration (r = -.252), reflecting a small to medium effect size and suggesting that individuals with a history of forced migration report lower levels of burnout. Additionally, burnout was positively correlated with LEC-5 scores (r = .364), indicating a medium effect size and suggesting that if providers have higher levels of personal trauma history, their burnout scores increase. Significant negative correlations were also found between burnout and scores on the POS8 (r = -.307) and Brief DSI (-.368), each representing medium effect sizes (Cohen, 1988). Thus, as individuals' perception of organizational support and level of differentiation decrease, burnout increases. Furthermore, a significant negative correlation was exhibited between Unhealthy Cope scores and Brief DSI scores (r = -.504) indicating a large effect size. This suggests that as reliance on unhealthy coping mechanisms increases, levels of differentiation decrease.

Analysis of Assumptions

Before conducting the hierarchical multiple regression analysis, I first evaluated whether the data met the model assumptions. A histogram of standardized residuals and P-P plot of standardized residuals were used to assess normality, and both demonstrated that the assumption of normality was met. A non-significant p-value on the Shapiro-Wilk test also confirmed normality (p = .082). Additionally, a scatterplot of standardized residuals indicated that the data met the assumption of homoscedasticity (equal variance of errors) as well as linearity. To assess multicollinearity among the predictor variables, both tolerance and variance inflation factors (VIF) were examined. Tolerance values greater than .10 and VIF values of less than 10 indicate multicollinearity is not a concern (Field, 2018). All values confirmed the absence of problematic multicollinearity (Age, Tolerance = .78, VIF = 1.28; Gender, Tolerance = .90, VIF = 1.11, ; History of forced migration, Tolerance = .87, VIF = 1.15; Healthy Cope, Tolerance = .74, VIF = 1.36; Unhealthy Cope, Tolerance = .56, VIF = 1.79; LEC-5, Tolerance = .85, VIF = 1.17; POS-8, Tolerance = .93, VIF = 1.07; Brief DSI, Tolerance = .65, VIF = 1.54). Additionally, while significant correlations existed among predictor variables, none exceeded the threshold of r = .80, further supporting the absence of problematic multicollinearity (Field, 2018). Therefore, as assumptions were met, I proceeded with a hierarchical multiple regression analysis with three steps.

Primary Analysis

To address the primary research hypothesis, I utilized a hierarchical multiple regression analysis with three steps. I hypothesized that differentiation of self would predict burnout among refugee service providers in the United States over and above known predictive factors (i.e. healthy and unhealthy coping mechanisms, personal history of trauma, and perception of

organizational support) after controlling for demographic variables (i.e. age, gender, and history of forced migration). Specifically, I hypothesized that lower scores of differentiation of self would statistically significantly predict higher burnout scores.

Results yielded by Step 1 of the hierarchical multiple regression analysis indicated that demographic factors significantly explained 18.9% of the variance in burnout: $F(3, 87) = 6.74$, $R^2 = .189$, $p < .001$, with a medium effect size as indicated by Cohen's $f^2 = .23$ (Cohen, 1988). Specifically, age ($B = -.174$, $\beta = -.342$, $p < .001$) and history of forced migration ($B = -.496$, $\beta = -.304$, $p < .01$) significantly predicted burnout. This suggests that a one standard deviation increase in age is associated with a .34 standard deviation decrease in burnout. Additionally, individuals with a history of forced migration reported burnout scores that were, on average, .30 standard deviations lower than those without a history of forced migration (history of forced migration: M = 2.35, SD = .51; no history of forced migration: M = 2.76, SD = .68). Gender ($B = .099$, $\beta = .063$, $p = .524$) was a nonsignificant predictor.

Step 2 of the hierarchical multiple regression analysis revealed that the addition of known predictors of burnout (i.e., healthy and unhealthy coping mechanisms, personal history of trauma, and perception of organizational support) significantly explained an additional 24% of the total variance in burnout: $F(4, 83) = 8.93$, $R^2 = .429$, $p < .001$. Investigation of individual predictors revealed that age ($B = -.135$, $\beta = -.265$, $p < .01$) and history of forced migration ($B = -.327$, $\beta = -.200$, $p < .05$) remained significant predictors of burnout. Additionally, unhealthy coping ($B = .460$, $\beta = .307$, $p < .01$), trauma history as measured by the LEC-5 ($B = .014$, $\beta = .228$, $p < .05$), and perceived organizational support ($B = -.186$, $\beta = -.268$, $p < .01$), significantly accounted for the variance in burnout. Specifically, a one standard deviation increase in unhealthy coping corresponds to a .31 standard deviation increase in burnout. Likewise, a one

standard deviation increase in trauma history is associated with a .23 standard deviation increase in burnout. Conversely, a one standard deviation increase in perceived organizational support was associated with a .27 standard deviation decrease in burnout. Healthy coping (B = -.037, β = -.034, p = .723) was a nonsignificant predictor. The overall effect size for Step 2 was large, as indicated by omega squared (ω^2 = .20) and Cohen's f^2 = .76 (Cohen, 1988).

Results from Step 3 of the hierarchical multiple regression analysis showed that differentiation of self did not significantly predict burnout over and above demographic factors, healthy coping, unhealthy coping, personal history of trauma, or perception of organizational support: $F(1, 82) = 8.25$, R^2 = .446, p = .120. Overall, in the final step, all variables of interest accounted for 44.6% of the variance in burnout among refugee service providers (R^2 = .446). Upon examination of individual predictors, age (B = -.115, β = -.226, $p < .05$) and history of forced migration (B = -.315, β = -.193, $p < .05$) once again remained significant, as did personal history of trauma as measured by the LEC-5 (B = .015, β = .237, $p < .01$) and perceived organizational support as measured by the POS-8 (B = -.184, β = -.266, $p < .01$). Specifically, in the full three-step model, a one standard deviation increase in trauma history corresponded to a .24 standard deviation increase in burnout. Additionally, a one standard deviation increase in perceived organizational support was associated with a .27 decrease in burnout. Unhealthy coping (B = .323, β = .216, p = .053), healthy coping (B = -.006, β = -.005, p = .957), and differentiation of self (B = -.150, β = -.160, p = .120) were nonsignificant predictors. The effect size for Step 3 was small, as indicated by omega squared (ω^2 = .01) (Field, 2018). However, the effect size for the full model was large as indicated by Cohen's f^2 = .79 (Cohen, 1988). A full model summary is presented in Table 4.

Table 4

Hierarchical Multiple Regression Model Summary and Coefficients for Predicting Burnout

Predictor	**B**	**95% CI**		**SE**	β	**t**	**F**	**R^2**	**ΔR2**
		LL	UL						
Step 1							6.74***	.19	**.19*** **
Gender	.10	-.21	.41	.16	.06	.64			
Age	-.17	-.28	.07	.05	-.34	-3.43***			
History of Forced Migration	-.50	-.82	-.18	.16	-.30	-3.07**			
Step 2							8.93***	.43	**.24*** **
Gender	.23	-.04	.51	.14	.15	1.70			
Age	-.14	-.23	-.04	.05	-.27	-2.94**			
History of Forced Migration	-.33	-.62	-.04	.15	-.20	-2.25*			
BriefCOPE-healthy	-.04	-.25	.17	.11	-.03	-.36			
BriefCOPE-unhealthy	.46	.18	.74	.14	.31	3.26**			
LEC-5	.01	.00	.03	.01	.23	2.55*			
POS8	-.19	-.30	-.07	.06	-.27	-3.13**			
Step 3							8.26***	.44	**.02**
Gender	.25	-.02	.52	.14	.16	1.84			
Age	-.12	-.21	-.02	.05	-.23	-2.42*			
History of Forced Migration	-.32	-.60	.03	.14	-.19	-2.19*			
BriefCOPE-healthy	-.01	-.22	.21	.11	-.01	-.05			
BriefCOPE-unhealthy	.32	-.00	.65	.17	.22	1.97			
LEC5	.02	.00	.03	.01	.24	2.67**			
POS8	-.18	-.30	-.07	.06	-.26	-3.13**			
Brief DSI	-.15	-.34	.04	.10	-.16	-1.57			

Note. N = 91. CI = confidence interval; LEC-5 = Life Events Checklist – 5; POS-8 = Perceived Organizational Support Scale – 8; Brief DSI = Brief Differentiation of Self Inventory

*p < .05. **p < .01. ***p < .001

Chapter Summary

The purpose of this chapter was to examine the results from the data analyses performed with 91 usable surveys. Specifically, utilizing a hierarchical multiple regression, this study examined the relationship between the criterion variable (burnout), and several steps of predictor variables including coping mechanisms, personal history of trauma, and perception of organizational support after controlling for age, gender, and history of forced migration. Results did not support the hypothesis that differentiation of self would be a unique predictor of burnout. However, differentiation of self was found to be significantly negatively correlated with burnout. Additionally, results did show that age, history of forced migration, personal history of trauma, and perception of organizational support are significant predictors of burnout among refugee service providers in the United States. The final regression model accounted for 44.6% of the variance in burnout.

CHAPTER FIVE

DISCUSSION

This study was designed to explore how demographics, a distinctive combination of factors identified as predictors of burnout in previous research (i.e. coping mechanisms, personal history of trauma, and perception of organizational support), as well as differentiation of self predict burnout among refugee service providers in the United States. Past research has shown that refugee service providers are uniquely at risk for burnout (Kim, 2017; Roberts et al., 2021). Although research exploring burnout among refugee service providers is expanding, it is limited and focuses mostly on providers in other countries (Birger et al., 2020; Posselt et al., 2018). The current study is important because it is the first to examine this unique combination of variables simultaneously regarding their relationship with burnout in this population. Additionally, differentiation of self, a tenet of Bowen Family Systems Theory (BFST), while identified as a predictor of burnout in other populations (Beebe & Frisch, 2009; Kursuncu et al., 2023), has not been examined among refugee service providers. Furthermore, this study builds the knowledge base regarding burnout in refugee service providers specifically in the United States, an identified gap in the literature (Akinsulure-Smith, et al., 2018). Thus, the purpose of this study was to expand previous research by examining a collection of variables simultaneously, through the unique lens of BFST, to explore their impact on the variance of burnout among refugee service providers in the United States.

Chapter one introduced the research question and purpose of this study, while chapter two provided a comprehensive literature review on the topics of burnout, refugee experiences,

and trauma, as well as a detailed explanation of the theoretical framework guiding this study. Chapter three outlined the research design, implementation, and instrumentation. Chapter four presented the study's results. The current chapter will discuss the findings of this study, analyze the results in relation to previous research, and discuss implications for counselors and counselor educators. Limitations of the study will also be described, along with suggestions for future research.

Summary of the Sample

This study consisted of responses from 91 refugee service providers who work directly with refugees in the United States. The majority of participants identified as female (77%), and Christian (62%), with 81% holding a bachelor's or graduate degree. While 44% identified as White, the sample included a diverse group of providers, representing racial/ethnic backgrounds from eight other global regions. Twenty-one percent of participants reported their own history of forced migration. Participants' tenure in their current positions ranged from one year to over 21 years. 32 individuals (35%) had been in their roles for 2-5 years, followed by 27% who had held their position for 1 year. The gender distribution in this study (77% female, 21% male) closely mirrors that of previous research (74% female, Akinsulure-Smith et al., 2018). However, the proportion of non-White participants in the study (56%) was notably higher than the 35% reported in earlier studies (Akinsulure-Smith et al., 2018). Additionally, while 37.4% of the sample in this study had achieved at least a bachelor's degree as compared to 53% in prior research (Akinsulure-Smith et al., 2018), an additional 44% had achieved a graduate or professional degree, indicating a more highly educated sample than previous research.

Preliminary Analysis

Correlations Between Study Variables

Burnout displayed significant correlations with multiple variables in the current study. Specifically, burnout scores were significantly negatively correlated with age, indicating that as age increases, burnout scores decrease. This finding mirrors previously published studies that also revealed a significant, negative correlation between burnout and age (Akinsulure-Smith et al., 2018; Espinosa, et al., 2019). Thus, it appears that as individuals get older, they are less likely to experience burnout as a result of their experiences serving refugee clientele. One possible explanation for this result is that, over time, providers develop healthy coping mechanisms, thus mitigating the effects of burnout. However, the data do not clarify whether this relationship is influenced by professional experience – whether older individuals have simply worked in the field longer – or if age is the only factor associated with reduced burnout, regardless of how long someone has worked with refugees. Additionally, these results are correlational, rather than causal, so specific explanations cannot be determined.

Additionally, a personal history of forced migration was significantly negatively correlated with burnout in this population. In other words, individuals who have themselves experienced forced migration were less likely to report symptoms of burnout than those who had not. While no prior research has directly examined the relationship between a history of forced migration and burnout in refugee service providers, related research has found that therapists with personal trauma histories – particularly trauma the same as clients – are more likely to experience secondary traumatic stress (Hensel et al., 2015). Interestingly, while that research identified a positive correlation between personal trauma shared with clients and secondary trauma, the current study found the opposite. One possible explanation is that refugee service

providers with lived experience of forced migration may find deeper meaning or a greater sense of purpose in their work, which could serve as a protective factor against burnout.

Moreover, unhealthy coping mechanisms were also found to be significantly correlated with burnout in this study, which aligns with previous research demonstrating similar results (Akinsulure-Smith et al., 2018; Espinosa et al., 2019). Thus, it seems that higher use of unhealthy coping mechanisms (such as substance use or behavioral disengagement) is associated with increased levels of burnout among providers. Interestingly, the use of healthy coping mechanisms was a non-significant predictor of burnout in this study. These findings suggest that the deleterious effects of unhealthy coping mechanisms outweigh any benefit of healthy coping mechanisms.

A personal history of trauma also demonstrated a strong positive correlation with burnout, meaning that as levels of personal trauma increased, burnout scores also increased. This is an interesting finding in light of the negative correlation between a history of forced migration and burnout, as forced migration is itself highly correlated with experiencing trauma (Henkelmann et al., 2020). However, this correlation confirms past research on history of trauma and burnout among refugee service providers, in which Akinsulure-Smith et al. (2018) found a statistically significant positive correlation between trauma history and burnout. Interestingly, these findings suggest that any personal history of trauma is connected with higher levels of burnout; however, a history of forced migration emerged in this study as a negative predictor. The fact that a personal history of trauma is associated with burnout makes sense as exposure to trauma is known to be detrimental to an individual's coping abilities, often leading to emotion dysregulation (van der Kolk, 2014). Thus, it is possible that a history of trauma leaves an individual less equipped to manage workplace stress.

Perception of organizational support displayed a strong, negative correlation to burnout in this study, indicating that as perceptions of organizational support decrease, burnout increases. These data again corroborate previous research that also found strong, negative correlations between perception of organizational support and burnout among refugee service providers in other countries (Eriksson et al., 2009; Kim, 2017). It appears that a strong sense of support from organizations protects against the impact of burnout in this population. Suggested in this data is the importance of providers feeling that their organization cares about them and their wellbeing.

Unique to this study is the finding that differentiation of self is strongly, negatively correlated with burnout among refugee service providers. These findings indicate that as differentiation of self scores decrease, burnout scores increase. While this finding is similar to previous research conducted in different populations (Beebe, 2007; Beebe & Frisch, 2009), no research has been conducted to date examining the relationship between differentiation of self and burnout among refugee service providers. The significant correlation found in the current study suggests that more research on this construct is needed to assess whether differentiation of self may provide a unique insight into the experiences of burnout in this population.

Interestingly, with regard to differentiation of self, unhealthy coping was significantly negatively correlated. Thus, as unhealthy coping mechanism scores increase, differentiation of self scores decrease. It is possible that differentiation of self and unhealthy coping mechanisms have some overlapping features. For example, differentiation of self is described as a self-regulating mechanism (Rizkalla & Segal, 2019), which may imply more healthy coping mechanisms are at play. It is possible that unhealthy coping mechanisms are more reactive in their nature, leading to less self-regulation. Thus, the inverse relationship between differentiation

of self and unhealthy coping mechanisms makes sense. More research is needed to fully understand the relationship between unhealthy coping and differentiation of self.

Primary Analysis

Statistically Significant Predictors of Burnout among Refugee Service Providers

The primary aim of this study was to examine whether differentiation of self predicts burnout among refugee service providers in the United States, over and above demographic factors (i.e. gender, age, and history of forced migration) and other predictors identified through the lens of Bowen Family Systems Theory (BFST) that have been previously linked to burnout in the literature. The full regression model explained 44.6% of the variance in burnout among refugee service providers (R^2 = .446). However, the addition of differentiation of self in Step 3 did not significantly improve the model, as ΔR^2 = .017, p = .120.

Overall, this study revealed that perception of organizational support and personal history of trauma were the strongest predictors of burnout as evidenced by their statistically significant beta coefficients in the final step of the regression model (e.g., β = -.266, p < .01 for organizational support; β = .237, p < .01 for personal history of trauma). Specifically, refugee service providers' perception of the support they receive from their organization, as well as their own experiences or exposure to traumatic events were the strongest predictors of burnout scores. The following section will examine all statistically significant variables in the final step of the regression model and contextualize the findings within the existing body of research.

Demographic Factors

Upon examination of the full model, two demographic variables significantly predicted burnout: age and history of forced migration. One potential explanation for the age-related findings is that older participants may represent those who have chosen to remain in the field and

have adapted well to its demands. Thus, it is possible that older providers have developed resiliency factors, such as greater emotion regulation skills and more clearly defined professional boundaries, developed through experience. In contrast, younger providers may not have had sufficient time or experience to cultivate these protective factors yet, placing them at greater risk for burnout. Additionally, a significant negative predictive relationship between a history of forced migration and burnout may be explained by an enhanced sense of purpose among individuals who share this history with clients, which could help mitigate the effects of burnout. Additionally, individuals with firsthand experience of forced migration may have developed more effective coping mechanisms out of necessity – coping strategies that may not be as developed in providers who do not share this history. These findings contribute to a broader understanding of how age and personal refugee experience can shape vulnerability to burnout in this field.

Personal History of Trauma

A personal history of trauma emerged as the second strongest statistically significant predictor of burnout among refugee service providers in the regression model. Although previous research on trauma history has yielded mixed findings (Akinsulure-Smith et al., 2018, Leung et al., 2022), its inclusion in the regression model was theoretically justified. Bowen Family Systems Theory suggests that a history of trauma would increase reactivity and stress in systems as well as individuals (Papero, 2017), warranting further exploration regarding its impact on burnout in the current study. Accordingly, the results did in fact indicate that a personal history of trauma predicted burnout in this population.

Previous research on refugee service providers has not consistently identified a personal history of trauma as a predictor of burnout. While studies in other populations have found a

significant link between trauma history and burnout (Kim et al., 2019; Mather et al., 2014), this relationship has not been supported in the context of refugee service work. For example, Akinsulure-Smith et al. (2018) found that trauma history was a nonsignificant predictor of burnout among refugee service providers in the United States. In contrast, the findings of the current regression model indicate that a personal history of trauma was a significant predictor of burnout, diverging from earlier research and offering a new perspective on the factors contributing to burnout in this population.

Several factors may explain these contradictory results. First, there is a nine-year gap between the two studies: Akinsulure-Smith et al. collected data in 2016, while the current study consists of data collected in 2025. Over this time period, significant sociopolitical changes or cultural shifts – particularly in the discourse around trauma or mental health – may have influenced how individuals perceive and report symptoms of burnout. Additionally, the COVID-19 pandemic occurred in the time between these two studies, a major global event that may have impacted how trauma and burnout manifest or are reported. Additionally, despite similarities in sample characteristics, there may be differences that could have contributed to the divergent findings, such as a difference in job roles. Specifically, Akinsulure-Smith et al. collected data exclusively from providers employed at six Refugee Resettlement Agencies (RRAs) in the United States. In contrast, the current study, while including participants from RRAs, also drew from a broader range of organizations that support the long-term needs of refugees, such as those offering medical care, legal services, and language support. Finally, different instruments were used to measure burnout in these two studies - the Oldenburg Burnout Inventory (OLBI) and the Copenhagen Burnout Inventory (CBI) - which may have led to variations in how the construct was measured, leading to contradictory results.

Perception of Organizational Support

In the current study, perceived organizational support emerged as the strongest predictor of burnout among refugee service providers, with a small effect size. This finding aligns with previous research demonstrating strong correlations between burnout and perceived organizational support in similar populations (Eriksson et al., 2009; Kim, 2017). However, both of these studies focused on providers outside of the United States. The findings of the current study suggest that organizational support may be a predictor of burnout across diverse cultural contexts, highlighting its critical role in mitigating burnout. Therefore, the present study contributes to the literature by offering evidence of a significant relationship between perception of organizational support and burnout specifically among refugee service providers working within the United States. Organizational support may include policies that prioritize employee well-being, opportunities for employees' opinions to be taken into account, and a demonstrated sense that employees' goals and values matter to the organization. Given this information, it appears that focusing on systemic factors such as organizational support, rather than solely focusing on individual factors such as coping strategies, may be more effective in addressing the deleterious impact of burnout.

Exploration of Non-Statistically Significant Regression Variables

Coping Mechanisms

Unhealthy Coping mechanisms were found to be a significant predictor of burnout among refugee service providers in the second step of the regression, however, this variable was no longer statistically significant in the final regression model. Despite this, unhealthy coping mechanisms were found to correlate with burnout and were also found to predict burnout above and beyond the demographic characteristics of age, gender, and history of forced migration.

These findings mirror previous research linking unhealthy coping strategies to burnout in this population (Akinsulure-Smith et al., 2018; Espinosa et al., 2019). However, the fact that unhealthy coping mechanisms were no longer statistically significant in the final step of the model suggests possible shared variance with the predictor added in the third step. In fact, unhealthy coping was found to be correlated with differentiation of self, the only variable added in the third step of the model. This highlights the importance of further exploration regarding the relationship between unhealthy coping and burnout, particularly in relation to differentiation of self, as it may offer valuable insights into the underlying dynamics of burnout and inform more effective intervention strategies.

Healthy coping mechanisms were not a significant predictor of burnout in any step of the hierarchical regression model. This finding is consistent with previous research, such as Espinosa et al. (2019), which found that while unhealthy coping strategies predicted burnout, healthy coping strategies did not. Notably, in the current study, healthy coping mechanisms were also not significantly correlated with any of the other variables examined, suggesting a limited role in explaining burnout or its related factors within this sample. These notable findings imply that counselors may achieve greater impact in reducing burnout by addressing and mitigating unhealthy coping strategies, rather than focusing on developing healthy ones.

Differentiation of Self

The results of this study did not support the primary hypothesis that differentiation of self would predict burnout in refugee service providers above and beyond demographic variables (i.e. age, gender, and history of forced migration), coping mechanisms (healthy and unhealthy), personal history of trauma, and perception of organizational support. Despite the negative statistically significant correlation between differentiation of self and burnout in the current

study, the variable was not a statistically significant predictor in the regression model. Differentiation of self has been shown in previous research to be correlated with burnout in other populations (Beebe & Frisch, 2009; Yavuz-Guler, 2023). In fact, a 2007 study found differentiation of self to be a predictor of burnout in clergypersons in the United States (Beebe, 2007). However, the relationship between differentiation of self and burnout has not yet been examined among refugee service providers. Despite the findings of this study indicating that differentiation of self is a nonsignificant predictor of burnout, more research is warranted as there may be shared variance with a predictor added in step two of the model that is impacting its predictive effect. In this current study, differentiation of self may not show any predictive power due to this shared variance.

Given the results of this study, counselors working with refugee service providers experiencing burnout may find that focusing on organizational support or personal history of trauma mitigates the effects of burnout more effectively than focusing on differentiation of self. However, given the fact that differentiation of self was found to correlate with burnout, interventions aimed at reducing burnout could include differentiation of self as a complementary focus, in addition to a primary focus on a stronger predictor of burnout such as organizational support.

Gender

In contrast to previous research, gender was not found to be a significant predictor of burnout in this population. In fact, gender was not found to be significantly correlated with any other variable examined in this study. Similar to healthy coping mechanisms, this indicates that gender does not explain burnout in the current study. Prior research has found that female gender significantly predicted burnout among refugee service providers in Turkey (Sagaltici et al.,

2022), and in the United States (Akinsulure-Smith et al., 2018). However, this study's regression results were contrary to these previous studies, as gender did not predict burnout in this sample. One possible explanation may lie in differences across sample compositions. The current study sample was 77% female, closely mirroring the Akinsulure-Smith sample, which was 73.6% female. In contrast, the Sagaltici et al. study included a more balanced sample, with only 48.7% female participants. The more equal gender distribution in the Sagaltici study may have contributed to their finding of gender as a significant predictor. However, despite the similarity in gender composition between the current study and the Akinsulure-Smith study, the differing outcomes may reflect other factors – such as variations in job roles, religious or spiritual affiliation, or race/ethnicity – which were not controlled for across studies.

Limitations

This study aimed to examine the predictors of burnout among refugee service providers in the United States. However, there are limitations to these findings that should be considered when interpreting the results. First, the majority of the participants in this study identified as female, Christian, and highly educated. Therefore, the findings of this study may not be generalizable among refugee service providers who identify as male, who follow other religious or spiritual traditions, or who have not attended college.

The sampling method used to collect the data in this study also has some limitations. Participants were recruited via a combination of convenience and snowball sampling. Specifically, I sent emails to refugee service organizations requesting participants who met the eligibility requirements and asked participants to forward the email to other individuals who may qualify and be willing to participate. Thus, the benefits of random sampling do not apply, and I was unable to calculate response rate.

Additionally, the data obtained for this study was gathered by self-report, making it impossible to verify for accuracy. Also, although survey results were anonymized, some items in the survey referenced sensitive topics, such as trauma history or perception of their workplace, which individuals may not have felt comfortable disclosing. The data was collected via a quantitative survey; thus, participants had no opportunity to explain or clarify any answers.

Finally, the timing of the data collection for this study is another limitation. Data was collected from February through mid-March of 2025. An executive order issued by the current President of the United States on January 27, 2025, abruptly suspended funding for refugee resettlement programs and imposed an immediate pause on refugee admissions into the country. This action has dramatically impacted the status of refugee operations in the United States, impacting refugees awaiting migration and those already resettled within the country. Refugee service providers are currently managing high levels of uncertainty about their jobs and increased stress about their ability to do their jobs. As a result of this executive order, hundreds of refugee service providers were laid off from their jobs, and some agencies were forced to close. These circumstances likely limited my ability to reach participants that met the inclusion criteria for this study, potentially impacting response rates. The results of this study may differ if data were collected at a different point in time.

Implications for Clinical Practice

The results of this study have several implications for counselors. Notably, burnout among refugee service providers in the United States remains largely underexplored in existing research. However, the burnout scores observed in this study, as measured by the Copenhagen Burnout Inventory (CBI), suggest that burnout is a relevant concern within this population ($M = 41.75$, $SD = 16.75$). For context, a 2020 study examining burnout among physicians reported

higher levels of burnout among general surgeons (M = 50.00, SD = 12.78; Caesar et al., 2020). While the scores in the present study are comparatively lower, they still reflect a meaningful level of burnout among refugee service providers. Therefore, counselors working with this population should be made aware of the potential for burnout and consider incorporating screening and preventative strategies into their practice.

Furthermore, perception of organizational support was found to be a statistically significant predictor of burnout. The theoretical framework guiding this study informed the choice of this variable for inclusion in the second step of the regression model, as did its established influence in the literature. A finding that one's work environment influences the experience of burnout is consistent with BFST's assumption that the health of an individual's workplace system influences their symptoms (Chambers, 2009; Papero, 2017). Burnout is a psychological syndrome resulting from work-related stress and is a higher risk for those in helping professions (Maslach, 2003; O'Connor et al., 2018). Therefore, when burnout is identified among clients who are refugee service providers, counselors should be informed of the impact of workplace support as a predictor and potentially use an instrument such as the POS-8 to screen for potential stressors that may influence the client's symptoms. For example, a client presenting with burnout may be most helped when the counselor considers not just individual factors such as emotion regulation, but also the health of the client's workplace. BFST would posit that an individual may be helped with individualized interventions such as stress management techniques, however, if the counselor does not evaluate the impact of the individual's workplace system, symptoms may not improve (Chambers, 2009).

Counselors may also benefit from using this study as a psychoeducational tool, informing refugee service provider clients of the connection between burnout and perception of

organizational support. Providing this psychoeducation regarding the importance of organizational support would foster increased insight regarding the health of the workplace system, allowing the client to change interactions within the workplace that would lead to a reduction in burnout. Specifically, counselors can encourage refugee service provider clients to self-advocate at work to foster more organizational support. This might entail seeking out supportive relationships at work, such as mentoring opportunities, or requesting policy changes that take their opinions and needs into account. Counselors can also encourage directors of refugee service organizations to increase their efforts to collaborate with providers, providing regular meetings where their experiences are being discussed and engaged with, thus potentially improving a sense of organizational support. Furthermore, counselors can serve in the role of consultant to help agencies develop policies that offer more organizational support to refugee service providers.

A personal history of trauma was also revealed to be a significant predictor of burnout in this study. This finding underscores the importance of counselors considering the role of past trauma when working with refugee service provider clients presenting with symptoms of burnout. Addressing unresolved trauma may be more effective than focusing solely on present-day symptoms. For example, counselors might utilize culturally adapted Cognitive Behavioral Therapy (CBT), which has shown efficacy in treating trauma-related symptoms (McFarlane & Kaplan, 2012). Additionally, Narrative Exposure Therapy (NET), a treatment protocol that has been shown to be effective in treating PTSD in displaced persons (Neuner et al., 2008), may be utilized by counselors working with refugee service providers, particularly if the providers are refugees themselves. Eye Movement Desensitization and Reprocessing (EMDR), a widely used

trauma treatment approach, has also been shown to reduce trauma symptoms and could be a valuable tool in supporting refugee service providers (Mavranezouli et al., 2020).

Past research has evaluated personal history of trauma utilizing the LEC-5 subscale that captures direct exposure to traumatic events (Akinsulure-Smith et al., 2018; Espinosa et al., 2019). In contrast, the present study employed the first four subscales of the LEC-5, which encompass a broader range of trauma exposure such as directly experiencing, witnessing, learning about, or encountering traumatic events as part of one's job. This more comprehensive assessment of trauma that includes learning about traumatic events aligns with prior findings that both vicarious traumatization and secondary traumatic stress are associated with trauma symptoms among refugee service providers (Ager et al., 2012; Kim, 2017; Roberts et al., 2021). Counselors working with refugee service providers should be trained to recognize the impact of both direct and indirect trauma exposure on the development of burnout within this population. Such training would support more effective screening practices, including the use of screening instruments like the LEC-5, which assesses exposure to a broad range of traumatic events relevant to this group. Incorporating this broader understanding into assessment and treatment can lead to more targeted and responsive interventions. Specifically, counselors may choose to address trauma on an organizational level by providing psychoeducational or support groups that teach providers about trauma and its impacts, or on an individual level by using trauma-focused therapy processes such as those listed above.

Age and a history of forced migration were also found to be significant predictors of burnout in this study. Counselors working with refugee service provider clients experiencing burnout should be informed that younger providers are more at risk of burnout, and screen for it accordingly. It could also be helpful for counselors to explore the reasons why being older is a

protective factor against burnout – potentially due to a deeper sense of purpose, more clearly defined boundaries, or more advanced clinical skills developed over time – and assist younger clients in cultivating these qualities. Likewise, the finding that a history of forced migration is associated with less burnout is important. This insight can help prevent assumptions that providers who share refugee status with their clients are automatically at greater risk for burnout. Instead, when burnout does occur in providers with a history of forced migration, well-informed counselors can be more attuned to other contributing factors, ensuring a more accurate and supportive response.

Implications for Advocacy

From an advocacy perspective, counselors may have an impact on burnout among refugee service providers by educating directors and policymakers about the constructs included in this study. Individuals in leadership of refugee serving organizations could be informed that perception of organizational support is a predictor of burnout, thus encouraging them to assess the health of the work environment in their organizations. Counselors could support this process by introducing tools such as the POS-8 to assess how staff and volunteers perceive organizational support. The results could offer valuable insights into specific areas of strength and concern, guiding actionable steps to enhance organizational health.

For example, if findings reveal that providers do not feel their well-being is prioritized, directors could implement wellness initiatives – such as access to counseling services, mindfulness programs, or group exercise – offered during the workday to promote self-care. Additionally, counselors could facilitate regular professional development opportunities through psychoeducational classes or workshops tailored to the needs of refugee service providers. Offering clinical supervision is another avenue through which counselors could support

providers' professional growth, reinforcing the perception that their organization is invested in their development and well-being. Counselors can also encourage mentoring relationships between older and younger providers, providing an opportunity for younger providers to learn professional and resiliency skills on the job.

Additionally, directors and policymakers should be made aware that the current study identified a personal history of trauma as a significant predictor of burnout among refugee service providers. In response, counselors could provide training regarding trauma informed care (TIC) for directors and providers. The Substance Abuse and Mental Health Services Administration (SAMHSA) identifies six principles of trauma informed care: (1) safety, (2) trustworthiness and transparency, (3) peer support, (4) collaboration and mutuality, (5) empowerment, voice and choice, and (6) cultural, historical, and gender responsiveness (SAMHSA, 2014). Incorporating TIC principles into the structure of organizations would mean transforming the culture of the organization through leadership, policy, training, and ongoing evaluation (SAMHSA, 2014). Specifically, this might mean changing the physical layout of an organization to foster a sense of welcome and safety. It could also mean creating or changing HR policies to include trauma-informed practices like flexible work accommodation or reflective supervision. Additionally, it could mean inviting counselors to provide psychoeducational groups focused on trauma recovery or facilitating access to trauma-informed counseling through referrals or financial support. Implementing TIC into organizational structures has been shown in prior research to result in higher levels of organizational support, and an increase in providers' awareness of their own trauma, leading to an increase in self-care (Damian et al., 2017). Counselors functioning in an advocate role for refugee service providers have a meaningful

opportunity to influence the culture of refugee serving organizations by promoting trauma-informed changes that can strengthen employees' sense of organizational support.

Implications for Counselor Educators

The findings of the current study suggest several important implications for counselor educators and counselor-training programs, particularly the need to prepare counselor trainees to work effectively with both refugees and the providers who serve them. While existing literature supports the integration of refugee populations into graduate level training programs (Kuo et al., 2019; Snow et al., 2021), there is no evidence of including training related to the needs of refugee service providers. Increasing awareness of both groups could represent a meaningful contribution of the present study and guide future curriculum development. Counselor educators might consider explicitly incorporating education on the refugee experience - including the resettlement process and its impact on both refugees and refugee service providers – into multicultural counseling courses. Similarly, the emotional toll and burnout risks faced by refugee service providers warrant inclusion in trauma, crisis, and career counseling courses. Given that burnout is a work-related construct, career counseling and introductory counseling courses offer natural spaces to explore its impact. Although burnout is a well-documented issue in counseling (Wardle & Mayorga, 2016), there is currently no evidence that career counseling courses address it directly. As both counselors and the clients they serve – such as refugee service providers – are at high risk for burnout, training programs should emphasize not only the recognition and treatment of burnout but also self-awareness and emotional regulation. Incorporating burnout education early in training could help future counselors build the insight and skills needed to manage their own symptoms and support clients more effectively. Intentionally addressing the needs of both refugee populations and their service providers throughout the counselor education

curriculum serves as a valuable form of advocacy and equips trainees to meet the demands of diverse and vulnerable populations with competence and compassion.

Additionally, counselor educators who work at institutions near refugee populations could take advantage of this proximity to expand advocacy work, creating assignments that require engagement with refugees or providers. Creating partnerships with refugee serving organizations could lead to practicum and internship opportunities in which trainees work directly with both populations. Counselor educators who are not near refugee serving agencies can invite providers as guest speakers, in person or virtually, or create cases studies related to refugee service providers, to help counselor trainees consider the needs of this population. The long-term effects of this could be significant, leading to increased comfort in counselors to work with refugees and providers who serve them and fostering awareness of a significant need that is often not incorporated into a counselor education process.

Specific to refugee service providers, developing an elective course focused on the needs of displaced people and those who serve them could be another meaningful application of this study's findings. This would be an important addition to any counselor education program, allowing interested students to become equipped to work with this marginalized and growing population. However, it would be especially meaningful at institutions located near refugee resettlement communities, increasing the opportunities to work with refugee clientele.

Implications for Future Research

The results of the current study provide direction for future research to continue to better understand burnout among refugee service providers. First, the current study found four variables that significantly predict burnout (perception of organizational support, personal history of trauma, age, and history of forced migration). Future research could explore the underlying

reasons these variables contribute to burnout. For example, studies that generate empirical data explaining why younger refugee service providers are more susceptible to burnout could inform strategies to better support and equip them. Similarly, understanding why a personal history of trauma influences burnout may enhance counselors' ability to treat and, more importantly, prevent burnout among providers. Such insights could also guide supervisors and program directors in creating more responsive and preventive organizational practices.

Future research on burnout in this population should also be collected at a different point in time when the current political climate has dissipated, which could lead to a larger sample of willing participants. Future research could also investigate how issues related to politics, such as immigration policy changes and funding cuts, impact burnout in refugee service providers. The current study did not examine this relationship; however, the current political climate has dramatically increased the stress level of refugees and their providers, raising the concern for a concurrent increase in burnout. This warrants further investigation in order to effectively meet the needs of this population. Additionally, future studies should include larger representations of important groups that were underrepresented in the study, such as males, and non-Christian religious and spiritual groups.

In addition, future research is needed to determine the impact of differentiation of self on burnout in different ways. For example, differentiation of self could be considered as a mediator in future studies. The relationship between differentiation of self and burnout is under-researched, and this study was the first to consider its impact on refugee service providers. Examining this construct more fully is important to understand its influence in this population.

Since perception of organizational support was the most statistically significant predictor of burnout in the present study, future studies could examine the factors associated with

organizational support in order to address burnout. Specifically, future researchers could assess factors associated with workplace health, such as supportive policies, supervisor support, transparent communication, or employee involvement in decision making in relation to burnout in this population. Furthermore, this study found that a history of forced migration predicted lower burnout scores. Future research examining the factors that explain this surprising finding could provide an in-depth view into the experiences of refugee service providers who share refugee status with their clients.

Qualitative studies into the experience of refugee service providers experiencing burnout would add important knowledge to the literature. Offering providers the opportunity to share details of their lived experiences as they serve refugees would provide a rich view into the experiences outlined by the quantitative data collected in this study. Quantitative data is an important way to gather information about the experiences of large groups of people, however, a qualitative examination of burnout in refugee service providers could expose factors that the limits of the current study's survey did not uncover.

Conclusions

The purpose of this study was to explore predictors of burnout among refugee service providers in the United States. A literature review revealed research linking unhealthy coping mechanisms, personal history of trauma, and perceived organizational support with burnout among refugee service providers. However, no research to date has investigated the relationship between differentiation of self and burnout in this population. In fact, research examining burnout among refugee service providers remains limited.

The present study found that age, a history of forced migration, personal history of trauma, and perceived organizational support statistically significantly predicted burnout in a

final regression model with a large effect size. Furthermore, several variables (differentiation of self, perceived organizational support, personal history of trauma, unhealthy coping mechanisms, history of forced migration, and age) were found to be statistically significantly correlated with burnout, lending empirical support to the topic of burnout in this population.

These results have implications for counselors and counselor educators, as well as future researchers. Counselors working with refugee service providers may benefit from screening for burnout in this population prior to diagnosing or choosing interventions. Additionally, developing interventions that address both individual and systemic factors contributing to symptoms may positively impact refugee service providers facing the demands of their work. Counselor educators can incorporate content regarding the needs and experiences of refugees and refugee service providers into appropriate course work. Furthermore, training counselors to utilize a systemic focus when evaluating the needs of refugee service providers may increase knowledge, awareness, and effectiveness in trainees seeking to work with this population. Further research into the underlying reasons the four statistically significant variables contribute to burnout is warranted, with the goal of informing strategies to prevent burnout before it develops. Furthermore, other implications for future research include examining the impact of differentiation of self on burnout without the variable of coping mechanisms, or as a mediator. Additionally, more research is necessary to explain the mitigating effects of a history of forced migration on burnout.

This study also serves to increase awareness of the unique needs of refugee service providers, particularly as the demands of their work dramatically increase. Although individual effect sizes ranged from small to medium, the full model demonstrated a large effect size, and the statistically significant findings highlight the importance of continued research to better

support this workforce. Counselors, counselor educators, and researchers may utilize the results of this study to further explore burnout among refugee service providers and to promote culturally responsive and humble advocacy efforts, as well as provide meaningful support through counseling tailored to the challenges of refugee service providers struggling with the demands of their work.

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APPENDIX A

RECRUITMENT EMAIL

Dear (Add Name),

My name is Deborah Smith, and I am a doctoral candidate in the Counselor Education and Supervision program at the University of Georgia. I am writing to invite you to participate in a research study I am conducting to learn more about the experiences of burnout among providers who work with refugees in the United States.

You have been selected because you work or volunteer at an agency that provides services to refugees in the United States.

If you agree to participate in this study, you will be provided with a link connecting you with a survey that is anticipated to take no more than 20 minutes to complete.

Participation in this study is voluntary, and you can refuse to take part or stop at any time. If you do participate, any information you share will be kept anonymous during and after the study.

If you are interested in participating, please reply to this email, and I will send a link to the survey, including an informed consent form.

Additionally, please reach out by phone, 678/468-5418, or email, Deborah.smith2@uga.edu if you have any questions about the study.

Thank you in advance for your participation!

Sincerely,

Deborah L. Smith, M.A., LPC
Doctoral Candidate

Department of Counseling and Human Development Services
Mary Frances Early College of Education
University of Georgia
Deborah.smith2@uga.edu

APPENDIX B

INFORMED CONSENT

Dear Participant,

My name is Deborah Smith, and I am a doctoral candidate at the University of Georgia. I am inviting you to participate in my dissertation research study (IRB 00011375), in collaboration with my dissertation chair, Dr. Amanda Giordano, Associate Professor in the Counseling and Human Development Services department at the University of Georgia.

The purpose of this research study is to learn more about burnout among social service providers who work with refugees in the United States. You are eligible for this study if you are at least 18 years old, have worked as an employee or volunteer at an agency serving the needs of refugees for at least one year, and have regular, weekly contact (on average) with refugees as part of your role.

If you agree to participate in this study, you will be asked to fill out the following survey that will take approximately 20 minutes to complete. You may choose to participate or not and can stop the survey at any point. Your responses to the survey will be anonymous and confidential.

This study asks questions about topics that may bring up uncomfortable thoughts, feelings, or memories. If you experience negative emotional responses, we encourage you to seek professional counseling, call a crisis help line, or visit the local emergency room. Contact information for crisis services is included below.

Thank you for considering participating in this survey! I recognize the stress, uncertainty, and challenges facing refugee communities as we navigate the changes brought on by recent executive orders. These circumstances have only strengthened my commitment to supporting

refugee service providers like you, who are working tirelessly to assist refugee clients during this tumultuous time. I hope this research contributes to greater support for you as you continue this vital work.

Your responses to this survey may help us better understand what predicts burnout among refugee service providers. By doing so, we can provide counselors and counselor educators with information to enhance their skills when working with refugee service providers, with a secondary potential benefit of providing better care to the refugees they serve. The first 125 eligible participants will be compensated with a $10 gift card to Walmart. Fraudulent responses will not be eligible for the gift card incentive.

If you have any questions about participation in this study, you may contact the co-investigator, Deborah Smith, at 678/468-5418, or by email at Deborah.Smtih2@uga.edu at any time. If you have any complaints or questions about your rights as a research volunteer, contact the IRB at 706/542-3199 or by email at IRB@uga.edu.

Sincerely,

Deborah L. Smith, MA, LPC, CPCS, Doctoral Candidate | Counselor Education and Supervision
Department of Counseling and Human Development Services
University of Georgia

Amanda Giordano, PhD, LPC, NCC
Associate Professor | Department of Counseling and Human Development Services
University of Georgia

Free Crisis Lifelines:

- Georgia Crisis and Access Line:

Phone: 1-800-715-4225

Also available to text via their app called MyGCAL

https://www.georgiacollaborative.com/providers/georgia-crisis-and-access-line-gcal/

- National Suicide Prevention Lifeline

Phone (English): 800-273-TALK (8255)

Phone (Spanish): 1-888-628-9454

Also available to chat via their website:

https://suicidepreventionlifeline.org/chat/

If you would like to use a crisis lifeline with tele-interpreter services, the National Suicide Prevention Lifeline offers tele-interpreter services in over 150 additional languages.

Samaritan's Call Helpline: 877-870-4673

If you are feeling depressed, lonely, suicidal, or just need to talk, call Samaritans' 24/7 Helpline at (877) 870-4673. When your call is answered, please say that you would like to speak to a volunteer in your preferred language.

APPENDIX C

ONE WEEK REMINDER EMAIL

Dear (Add Name),

Last week we sent you a survey in hopes you would agree to participate in our research study to learn more about the experiences of burnout among providers who work with refugees in the United States.

You are receiving this email because you work or volunteer at an agency that provides services to refugees in the United States. You are eligible to participate in this study if you (a) are 18 years old or older, (b) live in the United States, (c) are employed or volunteer at an agency that serves refugees in the United States, (d) have held this position for at least one year, and (d) have regular, direct contact with refugees as part of your employment/volunteer work.

If you agree to participate in this study, the link below will connect you with an online survey that is anticipated to take no more than 20 minutes to complete. All responses will be kept confidential during and after the study. Participation in this study is voluntary, and you can refuse to take part or stop at any time. The first 125 participants in this study will be compensated with a $10 Walmart gift card. Your email address will not be connected with survey responses, but will be required to obtain compensation. Fraudulent responses will not be eligible for compensation.

Survey link:

https://ugeorgia.ca1.qualtrics.com/jfe/form/SV_3C7a4SAPSjTmMui

Your participation in this study is important and appreciated. The information obtained by this research study will contribute to a growing body of research that will hopefully enhance the ability of counselors and counselor educators to address the issue of burnout in refugee service providers, and ultimately lead to better care for refugee populations themselves.

Please reach out by phone, 678/468-5418, or email, Deborah.smith2@uga.edu if you have any questions about the study. You may also reach Amanda Giordano, my faculty advisor, at amanda.giordaon@uga.edu.

Thank you in advance for your participation!

Sincerely,

Deborah L. Smith, M.A., LPC
Doctoral Candidate

Department of Counseling and Human Development Services
Mary Frances Early College of Education
University of Georgia
Deborah.smith2@uga.edu

APPENDIX D

TWO WEEK REMINDER EMAIL

Dear (Add Name),

Two weeks ago we sent you a survey in hopes you would agree to participate in our research study to learn more about the experiences of burnout among providers who work with refugees in the United States.

You are receiving this email because you work or volunteer at an agency that provides services to refugees in the United States. You are eligible to participate in this study if you (a) are 18 years old or older, (b) live in the United States, (c) are employed or volunteer at an agency that serves refugees in the United States, (d) have held this position for at least one year, and (d) have regular, direct contact with refugees as part of your employment/volunteer work.

If you agree to participate in this study, the link below will connect you with an online survey that is anticipated to take no more than 20 minutes to complete. All responses will be kept confidential during and after the study. Participation in this study is voluntary, and you can refuse to take part or stop at any time. The first 125 participants in this study will be compensated with a $10 Walmart gift card. Your email address will not be connected with survey responses, but will be required to obtain compensation. Fraudulent responses will not be eligible for compensation.

Survey link:

https://ugeorgia.ca1.qualtrics.com/jfe/form/SV_3C7a4SAPSjTmMui

Your participation in this study is important and appreciated. The information obtained by this research study will contribute to a growing body of research that will hopefully enhance the ability of counselors and counselor educators to address the issue of burnout in refugee service providers, and ultimately lead to better care for refugee populations themselves.

Please reach out by phone, 678/468-5418, or email, Deborah.smith2@uga.edu if you have any questions about the study. You may also reach Amanda Giordano, my faculty advisor, at amanda.giordaon@uga.edu.

Thank you in advance for your participation!

Sincerely,

Deborah L. Smith, M.A., LPC
Doctoral Candidate

Department of Counseling and Human Development Services
Mary Frances Early College of Education
University of Georgia
Deborah.smith2@uga.edu

APPENDIX E

COPENHAGEN BURNOUT INVENTORY

Part one: Personal burnout

Definition: Personal burnout is a state of prolonged physical and psychological exhaustion.

Questions:

1. How often do you feel tired?

2. How often are you physically exhausted?

3. How often are you emotionally exhausted?

4. How often do you think: ”I can’t take it anymore”?

5. How often do you feel worn out?

6. How often do you feel weak and susceptible to illness?

Response categories: Always, Often, Sometimes, Seldom, Never/almost never.

Total score on the scale is the average of the scores on the items.
If less than three questions have been answered, the respondent is classified as non-responder.

Part two: Work-related burnout

Definition: Work-related burnout is a state of prolonged physical and psychological exhaustion, which is perceived as related to the person’s work

Questions:

1. Is your work emotionally exhausting?

2. Do you feel burnt out because of your work?

3. Does your work frustrate you?

4. Do you feel worn out at the end of the working day?

5. Are you exhausted in the morning at the thought of another day at work?

6. Do you feel that every working hour is tiring for you?

7. Do you have enough energy for family and friends during leisure time?

Response categories:

Three first questions: To a very high degree, To a high degree, Somewhat, To a low degree, To a very low degree.
Last four questions: Always, Often, Sometimes, Seldom, Never/almost never. Reversed score for last question.
Scoring as for the first scale. If less than four questions have been answered, the respondent is classified as non-responder.

Part three: Client-related burnout

Definition: Client-related burnout is a state of prolonged physical and psychological exhaustion, which is perceived as related to the person's work with clients*.
*Clients, patients, social service recipients, elderly citizens, or inmates.

Questions:

1. Do you find it hard to work with clients?

2. Do you find it frustrating to work with clients?

3. Does it drain your energy to work with clients?

4. Do you feel that you give more than you get back when you work with clients?

5. Are you tired of working with clients?

6. Do you sometimes wonder how long you will be able to continue working with clients?

Response categories:

The four first questions: To a very high degree, To a high degree, Somewhat, To a low degree, To a very low degree.
The two last questions: Always, Often, Sometimes, Seldom, Never/almost never.
Scoring as for the first two scales. If less than three questions have been answered, the respondent is classified as non-responder.

APPENDIX F

NovoPsych

Brief - Coping Orientation to Problems Experienced Inventory (Brief-COPE)

Instructions:

The following questions ask how you have sought to cope with a hardship in your life. Read the statements and indicate how much you have been using each coping style.

		I haven't been doing this at all	A little bit	A medium amount	I've been doing this a lot
1	I've been turning to work or other activities to take my mind off things.	1	2	3	4
2	I've been concentrating my efforts on doing something about the situation I'm in.	1	2	3	4
3	I've been saying to myself "this isn't real".	1	2	3	4
4	I've been using alcohol or other drugs to make myself feel better	1	2	3	4
5	I've been getting emotional support from others.	1	2	3	4
6	I've been giving up trying to deal with it.	1	2	3	4
7	I've been taking action to try to make the situation better.	1	2	3	4
8	I've been refusing to believe that it has happened.	1	2	3	4
9	I've been saying things to let my unpleasant feelings escape.	1	2	3	4
10	I've been getting help and advice from other people.	1	2	3	4
11	I've been using alcohol or other drugs to help me get through it.	1	2	3	4
12	I've been trying to see it in a different light, to make it seem more positive.	1	2	3	4
13	I've been criticizing myself.	1	2	3	4
14	I've been trying to come up with a strategy about what to do.	1	2	3	4
15	I've been getting comfort and understanding from someone.	1	2	3	4
16	I've been giving up the attempt to cope.	1	2	3	4

NovoPsych

		I haven't been doing this at all	A little bit	A medium amount	I've been doing this a lot
17	I've been looking for something good in what is happening.	1	2	3	4
18	I've been making jokes about it.	1	2	3	4
19	I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.	1	2	3	4
20	I've been accepting the reality of the fact that it has happened.	1	2	3	4
21	I've been expressing my negative feelings.	1	2	3	4
22	I've been trying to find comfort in my religion or spiritual beliefs.	1	2	3	4
23	I've been trying to get advice or help from other people about what to do.	1	2	3	4
24	I've been learning to live with it.	1	2	3	4
25	I've been thinking hard about what steps to take.	1	2	3	4
26	I've been blaming myself for things that happened	1	2	3	4
27	I've been praying or meditating	1	2	3	4
28	I've been making fun of the situation.	1	2	3	4

Developer Reference:

Carver, C. S. (1997). You want to measure coping but your protocol'too long: Consider the brief cope. International journal of behavioral medicine, 4(1), 92-100.

APPENDIX G

LEC-5 Standard

Instructions: Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)	☐	☐	☐	☐	☐	☐
2. Fire or explosion	☐	☐	☐	☐	☐	☐
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)	☐	☐	☐	☐	☐	☐
4. Serious accident at work, home, or during recreational activity	☐	☐	☐	☐	☐	☐
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)	☐	☐	☐	☐	☐	☐
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)	☐	☐	☐	☐	☐	☐
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)	☐	☐	☐	☐	☐	☐
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)	☐	☐	☐	☐	☐	☐
9. Other unwanted or uncomfortable sexual experience	☐	☐	☐	☐	☐	☐
10. Combat or exposure to a war-zone (in the military or as a civilian)	☐	☐	☐	☐	☐	☐
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)	☐	☐	☐	☐	☐	☐
12. Life-threatening illness or injury	☐	☐	☐	☐	☐	☐
13. Severe human suffering	☐	☐	☐	☐	☐	☐
14. Sudden violent death (for example, homicide, suicide)	☐	☐	☐	☐	☐	☐
15. Sudden accidental death	☐	☐	☐	☐	☐	☐
16. Serious injury, harm, or death you caused to someone else	☐	☐	☐	☐	☐	☐
17. Any other very stressful event or experience	☐	☐	☐	☐	☐	☐

APPENDIX H

PERCEIVED ORGANIZATIONAL SUPPORT (POS-8)

The following questions are about your perceptions of the support you receive from your organization. Please think about your current place of employment or volunteer work, and respond to each statement based on your personal experiences. There are no right or wrong answers.

1=Strongly disagree, 2=Somewhat disagree, 3=Neither agree nor disagree, 4=Somewhat agree, 5=Strongly agree

1. My organization cares about my opinions
2. My organization cares about my wellbeing
3. My organization strongly considers my goals and values
4. Help is available from my organization when I have a problem
5. My organization would forgive an honest mistake on my part
6. If given the opportunity, my organization would take advantage of me (R)
7. My organization shows very little concern for me (R)
8. My organization is willing to help me if I need a special favor

APPENDIX I

BRIEF DIFFERENTIATION OF SELF INVENTORY

(Sloan & van Dierendonck, 2016): adapted from the
DSI-R (Skowron & Schmidt, 2004)

These are questions concerning your thoughts and feelings about yourself and relationships with others. Please read each statement carefully and decide how much the statement is generally true of you on a 1 (not at all) to 6 (very) scale. If you believe that an item does not pertain to you (e.g., you are not currently married or in a committed relationship, or one or both of your parents are deceased), please answer the item according to your best guess about what your thoughts and feelings would be in that situation. Be sure to answer every item and try to be as honest and accurate as possible in your responses.

1. I often feel inhibited around my family.R
2. No matter what happens in my life, I know that I'll never lose my sense of who I am.
3. When my spouse/partner criticizes me, it bothers me for days.R
4. At times my feelings get the best of me and I have trouble thinking clearly.R
5. When I am having an argument with someone, I can separate my thoughts about the issue from my feelings about the person.
6. I feel a need for approval from virtually everyone in my life.R
7. At times I feel as if I'm riding an emotional roller–coaster.R
8. There's no point in getting upset about things I cannot change.
9. I'm concerned about losing my independence in intimate relationships.R
10. I'm overly sensitive to criticism.R
11. I often feel that my spouse/partner wants too much from me.R
12. I often agree with others just to appease them.R
13. When one of my relationships becomes very intense, I feel the urge to run away from it.R
14. If someone is upset with me, I can't seem to let it go easily.R
15. I'm less concerned that others approve of me than I am in doing what I think is right.
16. I often feel unsure when others are not around to help me make a decision.R
17. I'm very sensitive to being hurt by others.R
18. When things go wrong, talking about them usually makes it worse.R
19. I tend to feel pretty stable under stress.
20. Sometimes I feel sick after arguing with my spouse/partner.R

DSI–R Subscale Composition: (underlined means reverse scored: e.g. 1=6, 2=5, etc.)

Emotional reactivity: 4, 7, 10, 14, 17;
"I" Position: 2, 5, 8, 15, 19;
Emotional cutoff: 1, 9, 11, 13, 18;
Fusion with others: 3, 6 , 12, 16, 20.

APPENDIX J

DEMOGRAPHIC QUESTIONNAIRE

For the following questions, please select the answer that best describes you

What is your age?
18-20
21-30
31-40
41-50
51-60
60+

What is your gender?
Male
Female
Non-binary
Prefer not to say

What is your race/ethnicity?
White
Black or African American
Hispanic or Latino
Southeast Asian (e.g., Myanmar, Cambodia, Vietnam)
South Asian (e.g., Bhutan, Nepal, Sri Lanka)
Middle Eastern or North African (e.g., Syria, Iraq, Afghanistan)
Central African (e.g., Democratic Republic of the Congo, Sudan)
East African (e.g., Somalia, Eritrea, Ethiopia)
Other

What is the highest level of education you have completed?
No formal education
Primary education
Secondary education (high school graduate)
Vocational/technical training
Bachelor's degree
Graduate or professional degree (e.g., master's, doctorate, medical, law)

Have you ever experienced forced migration? (being displaced from your home due to war, conflict, persecution, natural disaster, or other circumstances outside your control)
Yes
No
Prefer not to say

What is your primary role as a refugee service provider?
Case manager/case worker
Medical provider
Mental health provider
Legal advisor/immigration support provider
Advocacy/policy specialist
Language support provider (e.g., interpreter/translator, ESL instructor)
Education, housing, or job specialist
Director/executive leadership
Cultural orientation specialist
Other

How long have you held your current position, whether paid or volunteer?
1 year
2-5 years
6-10 years
11-20 years
21+ years

What is your religion or spiritual belief?
Christianity
Islam
Hinduism
Buddhism
Judaism
Atheism (do not believe in God or higher power)
Other

In your volunteer or staff position working with refugees, how frequently (on average) do you have direct contact with refugees, either virtually or in person?
Daily
Several times a week
About once a week
A few times a month
About once a month

TABLES

Table 1

Demographic Data of Participants

Variable		Frequency (*n*)	Percentage (%)
Age			
	18-20	3	3.3
	21-30	23	25.3
	31-40	23	25.3
	41-50	24	26.4
	51-60	10	11.0
	60+	8	8.8
Time on Job			
	1 year	25	27.8
	2-5 years	32	35.6
	6-10 years	18	20.0
	11-20 years	13	14.4
	21+ years	2	2.2
Education Level			
	No formal education	1	1.1
	Primary education	2	2.2
	Secondary education	10	11.0
	Vocational/technical training	4	4.4
	Bachelor's degree	34	37.4
	Graduate or professional degree	40	44.0
Primary Role			
	Case Manager/Case Worker	17	18.9
	Medical provider	8	8.9
	Mental health provider	8	8.9
	Legal advisor/immigration support provider	1	1.1
	Advocacy/policy specialist	1	1.1
	Language support provider		

	(interpreter/translator, ESL instructor)	7	7.8
	Education, housing or job specialist	12	13.3
	Director/executive leadership	9	10.0
	Cultural orientation specialist	1	1.1
	Other	27	28.9
Religion/Spirituality	Islam	13	14.1
	Hinduism	3	3.3
	Buddhism	0	0
	Judaism	2	2.2
	Atheism	8	8.7
	Christianity	57	62.0
	Other	10	10.9
Frequency of Contact with Refugee Clientele	Daily	41	45.1
	Several times a week	23	25.3
	About once a week	14	15.4
	A few times a month	10	11.0
	About once a month	7	7.7

N=91

Table 2

Descriptive Statistics of Survey Assessments

Instrument/Subscale	***M***	***SD***	**Cronbach's Alpha**	**# of Items**
CBI	41.75	16.75	.93	19
BriefCOPE Unhealthycope Subscale	1.86	.45	.75	12
BriefCOPE Healthycope Subscale	2.69	.60	.88	16
LEC-5	13.73	10.88	.93	17
POS-8	3.89	.96	.91	8
Brief DSI	4.31	.71	.82	20

Note. CBI = Copenhagen Burnout Inventory; BriefCOPE = Brief – Coping Orientation to Problems Experienced Inventory; LEC-5 = Life Events Checklist for DSM-5; POS-8 = Perceived Organizational Support Scale; Brief DSI = Brief Differentation of Self Inventory

Table 3

Correlation Matrix of All Study Variables

	CBI	Age	Gender	Forced Migration	Healthy Cope	Unhealthy Cope	LEC5	POS8	Brief DSI
CBI	1	-	-	-	-	-	-	-	-
Age	-.300**	1	-	-	-	-	-	-	-
Gender	.149	-.160	1	-	-	-	-	-	-
Forced Migration	-.252*	-.169	-.104	1	-	-	-	-	-
Healthy Cope	.023	.159	-.037	-.071	1	-	-	-	-
Unhealthy Cope	.366**	-.021	-.089	-.131	.410**	1	-	-	-
LEC-5	.364**	-.176	-.139	-.199	.035	.153	1	-	-
POS-8	-.307**	-.025	.017	-.006	.163	-.074	-.096	1	-
Brief DSI	-.368**	.259*	.058	.047	-.016	-.504**	-.094	.076	1

Note. CBI = Copenhagen Burnout Inventory; UNHEALTHY COPE = BriefCOPE Unhealthy Cope Subscale; HEALTHY COPE = BriefCOPE Healthy Cope Subscale; LEC-5 = Life Events Checklist; POS-8 = Perceived Organizational Support Scale; BRIEF DSI = Brief Differentiation of Self Inventory.
$N = 91$
$^{*}p < .05$. $^{**}p < .01$.

Table 4

Hierarchical Multiple Regression Model Summary and Coefficients for Predicting Burnout

Predictor	**B**	**95% CI**		**SE**	β	**t**	**F**	$\mathbf{R^2}$	**ΔR2**
		LL	UL						
Step 1							6.74***	.19	**.19*** **
Gender	.10	-.21	.41	.16	.06	.64			
Age	-.17	-.28	.07	.05	-.34	-3.43***			

History of Forced Migration	-.50	-.82	-.18	.16	-.30	-3.07**			
Step 2							8.93***	.43	**.24*** **
Gender	.23	-.04	.51	.14	.15	1.70			
Age	-.14	-.23	-.04	.05	-.27	-2.94**			
History of Forced Migration	-.33	-.62	-.04	.15	-.20	-2.25*			
BriefCOPE-healthy	-.04	-.25	.17	.11	-.03	-.36			
BriefCOPE-unhealthy	.46	.18	.74	.14	.31	3.26**			
LEC-5	.01	.00	.03	.01	.23	2.55*			
POS8	-.19	-.30	-.07	.06	-.27	-3.13**			
Step 3							8.26***	.44	**.02**
Gender	.25	-.02	.52	.14	.16	1.84			
Age	-.12	-.21	-.02	.05	-.23	-2.42*			
History of Forced Migration	-.32	-.60	.03	.14	-.19	-2.19*			
BriefCOPE-healthy	-.01	-.22	.21	.11	-.01	-.05			
BriefCOPE-unhealthy	.32	-.00	.65	.17	.22	1.97			
LEC5	.02	.00	.03	.01	.24	2.67**			
POS8	-.18	-.30	-.07	.06	-.26	-3.13**			
Brief DSI	-.15	-.34	.04	.10	-.16	-1.57			

Note. $N = 91$. CI = confidence interval; LEC-5 = Life Events Checklist – 5; POS-8 = Perceived Organizational Support Scale – 8; Brief DSI = Brief Differentiation of Self Inventory

*$p < .05$. **$p < .01$. ***$p < .001$